

<i>SERFF Tracking Number:</i>	<i>NWST-128300321</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Northwestern Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.002 Short Term</i>
<i>Product Name:</i>	<i>MN 992-STD/0911</i>		
<i>Project Name/Number:</i>	<i>MN 992-STD/0911/MN 992-STD/0911</i>		

## Filing at a Glance

Company: The Northwestern Mutual Life Insurance Company

Product Name: MN 992-STD/0911	SERFF Tr Num: NWST-128300321	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved	State Tr Num:
Sub-TOI: H11G.002 Short Term	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Donna Lambert
	Authors: Alan Smith, Sharon Denman, Blanche Sabo	Disposition Date: 07/02/2012
	Date Submitted: 05/07/2012	Disposition Status: Approved
Implementation Date Requested:		Implementation Date:

State Filing Description:

## General Information

Project Name: MN 992-STD/0911	Status of Filing in Domicile: Pending
Project Number: MN 992-STD/0911	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filing submitted to Wisconsin, our state of domicile, on May 7, 2012.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer, Association, Trust, Other	Explanation for Other Group Market Type: Union
Overall Rate Impact:	Filing Status Changed: 07/02/2012
	State Status Changed: 07/02/2012
Deemer Date:	Created By: Sharon Denman
Submitted By: Sharon Denman	Corresponding Filing Tracking Number:
Filing Description:	
The Northwestern Mutual Life Insurance Company is filing for review and approval Group Short Term Disability Insurance Policy Amendment Form MN 992-STD/0911 and the corresponding Group Short Term Disability Insurance Certificate Attachment Form MN 992-STDC/0911. These forms do not replace any previously approved forms.	

Our Group Short Term Disability product, filed under Group Policy Form MN 992-STD and Group Certificate Form MN 992-STDC, was approved for use in your state effective July 30, 1993.

*SERFF Tracking Number:* NWST-128300321 *State:* Arkansas  
*Filing Company:* The Northwestern Mutual Life Insurance *State Tracking Number:*  
Company  
*Company Tracking Number:*  
*TOI:* H11G Group Health - Disability Income *Sub-TOI:* H11G.002 Short Term  
*Product Name:* MN 992-STD/0911  
*Project Name/Number:* MN 992-STD/0911/MN 992-STD/0911

The amendment provides options for the working claimant, paid time off, and enhancement of Temporary Recovery with cancer treatment that can be selected by the Employer.

The specific design of each group policy is negotiated and agreed upon by Northwestern Mutual and the Policyowner at the time of policy issue. The appropriate language is then automatically included in the body of the policy and certificate.

The forms meet and exceed the requirements of the Arkansas Life and Disability Insurance Policy Language Simplification Act, when included within the base policy and certificate.

There is no deviation from generally accepted insurance practices.

This group insurance product is, and will continue to be, marketed through normal insurance channels (insurance brokers and representatives) to groups traditionally eligible for group insurance. The majority of group policies will be issued to employers to cover their employees.

While the attached forms are submitted on 8 ½ by 11 pages, we may also print the same text in a booklet format (5 ½ by 8 ½ pages) or on electronic media (e.g. CD-ROM, Internet), if requested by the Policyowner. We may also issue certificates in a foreign language, based upon a direct translation of the filed wording.

Please feel free to contact me with any questions you may have, or if you need anything further with respect to this filing.

Sincerely,  
Sharon K. Denman  
Senior Compliance Analyst  
Group Insurance Administration  
Phone: (971) 321-6842  
Fax: (971) 321-8369  
sharon.denman@standard.com  
State Narrative:

## **Company and Contact**

### **Filing Contact Information**

SERFF Tracking Number: NWST-128300321 State: Arkansas

Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term

Product Name: MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

Sharon Denman, Senior Compliance Analyst sharon.denman@standard.com  
 900 SW Fifth Avenue 971-321-6842 [Phone]  
 C14C 971-321-8369 [FAX]  
 Portland, OR 97204

### Filing Company Information

The Northwestern Mutual Life Insurance Company CoCode: 67091 State of Domicile: Wisconsin  
 720 East Wisconsin Avenue Group Code: 860 Company Type: Life  
 Rm S845 Group Name: State ID Number:  
 Milwaukee, WI 53202 FEIN Number: 39-0509570  
 (414) 271-1444 ext. [Phone]

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### Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: %0.00 per form x 2 forms  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Northwestern Mutual Life Insurance Company	\$100.00	05/07/2012	58993083

SERFF Tracking Number:	NWST-128300321	State:	Arkansas
Filing Company:	The Northwestern Mutual Life Insurance Company	State Tracking Number:	
Company Tracking Number:			
TOI:	H11G Group Health - Disability Income	Sub-TOI:	H11G.002 Short Term
Product Name:	MN 992-STD/0911		
Project Name/Number:	MN 992-STD/0911/MN 992-STD/0911		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	07/02/2012	07/02/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	06/07/2012	06/07/2012	Sharon Denman	06/29/2012	06/29/2012
Pending Industry Response	Donna Lambert	05/30/2012	05/30/2012	Sharon Denman	06/29/2012	06/29/2012
Pending Industry Response	Donna Lambert	05/10/2012	05/10/2012	Sharon Denman	05/24/2012	05/24/2012

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	previously approved MN 992-STD and MN 992-STDC July 30, 1993	Sharon Denman	05/24/2012	05/24/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
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*SERFF Tracking Number:*      *NWST-128300321*      *State:*      *Arkansas*  
*Filing Company:*      *The Northwestern Mutual Life Insurance*      *State Tracking Number:*  
    *Company*  
*Company Tracking Number:*  
*TOI:*      *H11G Group Health - Disability Income*      *Sub-TOI:*      *H11G.002 Short Term*  
*Product Name:*      *MN 992-STD/0911*  
*Project Name/Number:*      *MN 992-STD/0911/MN 992-STD/0911*

Section #s in 6/7/12 Objection Letter	Note To Filer	Donna Lambert	06/07/2012 06/07/2012
Revision to Item #5	Note To Filer	Donna Lambert	06/07/2012 06/07/2012
response to Note to Filer dated 5/30/2012	Note To Reviewer	Sharon Denman	05/31/2012 05/31/2012
Question About July 16, 1993 Letter to John Shields	Note To Filer	Donna Lambert	05/30/2012 05/30/2012

<i>SERFF Tracking Number:</i>	<i>NWST-128300321</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Northwestern Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.002 Short Term</i>
<i>Product Name:</i>	<i>MN 992-STD/0911</i>		
<i>Project Name/Number:</i>	<i>MN 992-STD/0911/MN 992-STD/0911</i>		

## Disposition

Disposition Date: 07/02/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NWST-128300321 State: Arkansas

Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term

Product Name: MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	previously approved MN 992-STD and MN 992-STDC July 30, 1993	Approved	Yes
Supporting Document	previously approved MN 992-LTD and MN 992-LTDC July 30, 1993	Replaced	Yes
Supporting Document	previously approved DOL	Approved	Yes
Supporting Document	previously approved physician definition	Approved	Yes
Supporting Document	previously approved Time Of Payment	Approved	Yes
Supporting Document	previously approved Allocation	Approved	Yes
Supporting Document	Guaranty Association Notice	Approved	Yes
Supporting Document	Policy Info Notice	Approved	Yes
Supporting Document	STD Sample Policy	Approved	Yes
Form (revised)	Amendment Group Short Term Disability Policy	Approved	Yes
Form	Amendment Group Short Term Disability Policy	Replaced	Yes
Form (revised)	Amendment Group Short Term Disability Certificate	Approved	Yes
Form	Amendment Group Short Term Disability Certificate	Replaced	Yes

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/07/2012  
Submitted Date 06/07/2012  
Respond By Date 07/09/2012

Dear Sharon Denman,

After making these revisions to the policy, and applicable corresponding revisions to the certificate, please attach the forms to the Form Schedule tab for final review.

### Objection 1

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: Please add a clean claims provision. RR 43 Sec. 12(a).

### Objection 2

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: Policy Section 7.4, Time of Payment of Claim.

Loss of time benefits must be paid not later than every 30 days (not 60). ACA 23-86-108(6)

### Objection 3

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: Revise the Information to Accompany Policies Notice. Bulletin 15-2009

### Objection 4

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: Revise the Arkansas Life and Health Insurance Guaranty Association Act notice. RR 49 Appendix A

### Objection 5

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: Page 27 of the policy, Physician or Practitioner.

Services provided by a psychological examiner must be paid if the contract provides benefits for mental health coverage. ACA 23-79-142.

### Objection 6

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: Review RR 18 Sec. 5 and revise any definitions that do not match those in this Rule.



A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.  
Sincerely,  
Donna Lambert

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/29/2012  
Submitted Date 06/29/2012

Dear Donna Lambert,

### Comments:

Thank you for the Objectin Letter of June 7, 2012.

### Response 1

Comments: We believe the Notice Of Decision section of our previously approved DOL amendment complies with RR 43 Sec. 12(a). Please also see page 13 of the sample policy.

#### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

Please add a clean claims provision. RR 43 Sec. 12(a).

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: previously approved DOL

Comment:

Satisfied -Name: STD Sample Policy

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### Response 2

Comments: Please see previously apporved Time Of Payment and page 12 of the sample policy. I believe you had also asked for the previously approved Allocation.

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

Policy Section 7.4, Time of Payment of Claim.

Loss of time benefits must be paid not later than every 30 days (not 60). ACA 23-86-108(6)

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: previously approved Time Of Payment

Comment:

Satisfied -Name: previously approved Allocation

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### Response 3

Comments: I've attached the Policy Information Notice currently in use. We believe it complies with Bulletin 15-2009.

### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

Revise the Information to Accompany Policies Notice. Bulletin 15-2009

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Policy Info Notice

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

*SERFF Tracking Number:* NWST-128300321 *State:* Arkansas  
*Filing Company:* The Northwestern Mutual Life Insurance *State Tracking Number:*  
Company  
*Company Tracking Number:*  
*TOI:* H11G Group Health - Disability Income *Sub-TOI:* H11G.002 Short Term  
*Product Name:* MN 992-STD/0911  
*Project Name/Number:* MN 992-STD/0911/MN 992-STD/0911

## Response 4

Comments: Attached is the Guaranty Association Notice we currently provide.

### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

Revise the Arkansas Life and Health Insurance Guaranty Association Act notice. RR 49 Appendix A

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Guaranty Association Notice

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 5

Comments: A previously approved amendment includes the definition of Physician we believe complies with ACA 23-79-142.

### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

Page 27 of the policy, Physician or Practitioner.

Services provided by a psychological examiner must be paid if the contract provides benefits for mental health coverage. ACA 23-79-142.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: previously approved physician definition

Comment:

No Form Schedule items changed.

SERFF Tracking Number: NWST-128300321 State: Arkansas

Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term

Product Name: MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

No Rate/Rule Schedule items changed.

## Response 6

Comments: Just as with the physician definition, it is possible other definitions have been revised and approved. If you would please specify which definitions you feel are out of compliance, I would be happy to see if they have been revised and approved.

The May 30, 2012 Obejction included a request to modify the two Incontestability provisions. We do not have those modifications previously approved. I have added them to the amendments submitted for approval in this filing. Since that previous objection is not here, I'm attaching those revisions here. Otherwise I don't believe you can access them.

### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

Review RR 18 Sec. 5 and revise any definitions that do not match those in this Rule.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Amendment Group Short Term Disability Policy	MN 992-STD/0911		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		54.000	revised MN 992 STD 0911.pdf
<b>Previous Version</b>							
Amendment Group Short Term Disability Policy	MN 992-STD/0911		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		54.000	MN 992 STD 0911.pdf
Amendment Group	MN 992-		Certificate Amendment,	Initial		54.000	revised

SERFF Tracking Number: NWST-128300321 State: Arkansas

Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term

Product Name: MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

Short Term Disability Certificate	STDC/091 1	Insert Page, Endorsement or Rider	MN 992 STDC 0911.pdf
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**Previous Version**

Amendment Group	MN 992-	Certificate Amendment, Initial	54.000	MN 992
Short Term Disability Certificate	STDC/091 1	Insert Page, Endorsement or Rider		STDC 0911.pdf

No Rate/Rule Schedule items changed.

I hope I have met your objections satisfactorily. I will be out of the office until JULY 10. Please do not hesitate to contact me with further questions regarding this filing.

Sincerely,  
Alan Smith, Blanche Sabo, Sharon Denman

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 05/30/2012  
Submitted Date 05/30/2012  
Respond By Date 07/02/2012

Dear Sharon Denman,

This will acknowledge receipt of the captioned filing.

### Objection 1

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment: A few revisions need to be made to bring this policy into compliance.

1. Please add a clean claims provision. RR 43 Sec. 12(a)
2. Loss of time benefits must be paid not later than every 30 days (not 60). 23-86-108(6)
3. Revise the Information to Accompany Policies Notice. Bulletin 15-2009
4. Revise the Arkansas Life and Health Insurance Guaranty Association Act notice. RR 49 Appendix A
5. Please make separate Misrepresentation on Application and Incontestability provisions to make this information clearer to the consumer. Use 23-86-107 for incontestability wording; see 23-79-107 for misrepresentation on application language.
6. Review RR 18 Sec.5 and revise any definitions that do not match those in this section.
7. After making these revisions, and applicable corresponding revisions to the Certificate. Please attach the policy and certificate to the Supporting Documentation tab for final review.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/29/2012  
Submitted Date 06/29/2012

Dear Donna Lambert,

### Comments:

Thank you for the Objection letter of May 30. Per the Note to Filer; Revision to Item #5, dated June 7, 2012, all of my responses are on the Objection letter of June 7, 2012.

### Response 1

Comments: Thank you for resubmitting this Objection letter on June 7, 2012. I appreciate each item being a separate objection.

### Related Objection 1

Applies To:

- previously approved MN 992-STD and MN 992-STDC July 30, 1993 (Supporting Document)

Comment:

A few revisions need to be made to bring this policy into compliance.

1. Please add a clean claims provision. RR 43 Sec. 12(a)
2. Loss of time benefits must be paid not later than every 30 days (not 60). 23-86-108(6)
3. Revise the Information to Accompany Policies Notice. Bulletin 15-2009
4. Revise the Arkansas Life and Health Insurance Guaranty Association Act notice. RR 49 Appendix A
5. Please make separate Misrepresentation on Application and Incontestability provisions to make this information clearer to the consumer. Use 23-86-107 for incontestability wording; see 23-79-107 for misrepresentation on application language.
6. Review RR 18 Sec.5 and revise any definitions that do not match those in this section.
7. After making these revisions, and applicable corresponding revisions to the Certificate. Please attach the policy and certificate to the Supporting Documentation tab for final review.

### Changed Items:

No Supporting Documents changed.



State: *Arkansas*

*State Tracking Number:*

Sub-TOI: *H11G.002 Short Term*

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

No Rate/Rule Schedule items changed.

Alan Smith, Blanche Sabo, Sharon Denman

SERFF Tracking Number:	NWST-128300321	State:	Arkansas
Filing Company:	The Northwestern Mutual Life Insurance Company	State Tracking Number:	
Company Tracking Number:			
TOI:	H11G Group Health - Disability Income	Sub-TOI:	H11G.002 Short Term
Product Name:	MN 992-STD/0911		
Project Name/Number:	MN 992-STD/0911/MN 992-STD/0911		

# Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/10/2012
Submitted Date	05/10/2012
Respond By Date	06/11/2012

Dear Sharon Denman,

Please send copies of Group Policy Form MN 992-STD and Group Certificate Form MN 992-STDC, approved July 30, 1993.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.  
Sincerely,  
Donna Lambert

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 05/24/2012  
Submitted Date 05/24/2012

Dear Donna Lambert,

### Comments:

Thank you for the objection letter of 5/10/12.

### Response 1

Comments: A copy of the previously approved Group Policy Form MN 992-LTD and Group Certificate Form MN 992-LTDC is under the Supporting Documentation tab.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: previously approved MN 992-LTD and MN 992-LTDC July 30, 1993

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We hope this addition meets with your approval.

Sincerely,

Alan Smith, Blanche Sabo, Sharon Denman

SERFF Tracking Number: NWST-128300321

State: *Arkansas*

*Filing Company:* *The Northwestern Mutual Life Insurance Company*

*State Tracking Number:*

*Company Tracking Number:*

*TOI: H11G Group Health - Disability Income*

Sub-TOI: *H11G.002 Short Term*

*Product Name:* MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Note To Filer

**Created By:**

Donna Lambert on 06/07/2012 01:35 PM

**Last Edited By:**

Donna Lambert

## Submitted On:

07/02/2012 12:35 PM

**Subject:**

Section #s in 6/7/12 Objection Letter

**Comments:**

It looks like some of the section numbers referenced in my objection letter are incorrect. I'm sure you can find these provisions without that information, but I apologize for the error.



## Note To Reviewer

Sharon Denman on 05/31/2012 10:30 AM

Donna Lambert

07/02/2012 12:35 PM

response to Note to Filer dated 5/30/2012

**Comments:**

Yes, that is the sentence that was removed.

Contracts were not issued without the removal of the sentence. They were issued with the approved Allocation of Authority language.

I have attached the approved Allocation of Authority pages. I apologize for the oversight.

I hope this explanation meets with your apporval.

Please contact me if you have further questions regarding this filing.

Thank you

review.

The Company will review your claim promptly after receiving your request. The Company will send you a notice of its decision within 60 days after receiving your request, or within 120 days if special circumstances require an extension. The Company will state the reasons for its decision and refer you to the relevant parts of the Policy.

#### **6.9 TIME LIMITS ON LEGAL ACTIONS**

No action at law or in equity may be brought until 60 days after you have given the Company Proof Of Loss. No such action may be brought more than three years after the earlier of:

- \* The date the Company receives Proof Of Loss; and
- \* The end of the period within which Proof Of Loss is required to be given.

#### **SECTION 7. ALLOCATION OF AUTHORITY**

Except for those functions which the Policy specifically reserves to the Policyowner, the Company has full and exclusive authority to control and manage the Policy, to administer claims, and to interpret the Policy and resolve all questions arising in the administration, interpretation, and application of the Policy.

The Company's authority includes, but is not limited to:

- \* The right to resolve all matters when a review has been requested;
- \* The right to establish and enforce rules and procedures for the administration of the Policy and any claim under it;
- \* The right to determine:
  - (1) Your eligibility for insurance;
  - (2) Your entitlement to benefits;
  - (3) The amount of benefits payable to you;
  - (4) The sufficiency and the amount of information the Company may reasonably require to determine 1, 2, or 3 above.

**APPROVED**

**JUL 30 1993**

**Insurance Commissioner  
State of Arkansas**

review.

The Company will review your claim promptly after receiving your request. The Company will send you a notice of its decision within 60 days after receiving your request, or within 120 days if special circumstances require an extension. The Company will state the reasons for its decision and refer you to the relevant parts of the Policy.

#### 6.9 TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given the Company Proof Of Loss. No such action may be brought more than three years after the earlier of:

- \* The date the Company receives Proof Of Loss; and
- \* The end of the period within which Proof Of Loss is required to be given.

**APPROVED**  
**JUL 30 1993**

*Insurance Commissioner  
State of Arkansas*

#### SECTION 7. ALLOCATION OF AUTHORITY

Except for those functions which the Policy specifically reserves to the Policyowner, the Company has full and exclusive authority to control and manage the Policy, to administer claims, and to interpret the Policy and resolve all questions arising in the administration, interpretation, and application of the Policy.

The Company's authority includes, but is not limited to:

- \* The right to resolve all matters when a review has been requested;
- \* The right to establish and enforce rules and procedures for the administration of the Policy and any claim under it;
- \* The right to determine:
  - (1) Your eligibility for insurance;
  - (2) Your entitlement to benefits;
  - (3) The amount of benefits payable to you;
  - (4) The sufficiency and the amount of information the Company may reasonably require to determine 1, 2, or 3 above.



## Note To Filer

Donna Lambert on 05/30/2012 12:25 PM

Donna Lambert

07/02/2012 12:35 PM

## Question About July 16, 1993 Letter to John Shields

The letter addresses the removal of "the last sentence of the Allocation of Authority provision."

Was the following sentence the sentence that was to be removed before the policy was issued: Subject to the review procedures of the Policy, any decision the Company makes in the exercise of the Company's authority is conclusive and binding.

Was the contract issued without the removal of the sentence?

## Amendment Letter

SERFF Tracking Number: NWST-128300321 State: Arkansas

Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term

Product Name: MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/02/2012	MN 992-STD/0911	Policy/Cont Amendment Group ract/Fratern Short Term Disability al Policy Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		54.000	revised MN 992 STD 0911.pdf
Approved 07/02/2012	MN 992-STDC/0911	Certificate Amendmen Short Term Disability t, Insert Certificate Page, Endorseme nt or Rider	Initial		54.000	revised MN 992 STDC 0911.pdf

## AMENDMENT TO GROUP SHORT TERM DISABILITY INSURANCE POLICY FORM

Attached to and made a part of Group Policy Form MN 992-STD

Group Policy Form MN 992-STD is amended to provide an update to policy language and to provide the following provisions for any Policyowner who negotiates the inclusion of such provisions into its Short Term Disability policy issued by us. The use of brackets ( [ ] ) indicate the language is optional or variable; optional language is either included or removed in entirety, while variable language shows possible language choices or the most common number range used within the brackets.

1. In order to provide loss of license language, **SECTION 2.3 DEFINITION OF DISABILITY**, is amended to add the following language:

**[Optional:**

Note: you are not Disabled from your Own Occupation merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license. The loss of a professional license, occupational license, or certification does not, in itself, constitute Disability.]

2. **SECTION 2.3 DEFINITION OF DISABILITY** is amended to add the following language:

**[Optional:**

**Own Occupation.** This is the job you are regularly performing for your Employer when Disability begins.]

**[Optional:**

**Material Duties.** These are the usual duties you perform in your regular job with your Employer.]

3. **SECTION 2.5 BENEFIT AMOUNTS**, is amended to add the following language:

**[Optional:**

**Return To Work Benefit.** The Return To Work Benefit will be paid in place of your STD Benefit, if you are working while Disabled. Your Return To Work Benefit equals your STD Benefit minus the amount of your **[Optional; Work Earnings,]** **[Optional; sick pay,]** **[Optional; annual or personal leave pay,]** **[Optional; severance pay,]** **[Optional; Paid Time Off,]** **[Optional; or other salary continuation,]** **[Optional; including donated amounts]** **[Optional; (but not vacation pay]** **[Optional; or Paid Time Off)]** which, when added to your STD Benefit, exceeds **[Variable; 100%]** of your Predisability Earnings.

4. The following sections are amended to add Paid Time Off as follows:

**SECTION 4. EXCLUSIONS AND LIMITATIONS** of the **SPECIFICATIONS** section:

**4.2 LIMITATIONS**

**[Optional Limitation:**

\* **[Variable;** Paid Sick Leave;

**- Or -**

Paid Time Off]

**SECTION 2. BENEFITS**

**2.2 BENEFIT TERMS**

**[Optional;**

**Paid Time Off.** This is **[Variable;** e.g. vacation pay/sick pay/annual or personal leave pay] provided by your Employer.]

**SECTION 3. BENEFIT PROVISIONS**

**3.1 OTHER INCOME**

**Other Income.** The amounts below are Other Income:

**[Optional:**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer;

**- Or -**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;]

**SECTION 4. EXCLUSIONS AND LIMITATIONS**

**4.2 LIMITATIONS**

**[Optional:**

**Paid Sick Leave.** No benefits will be paid for any period when you are receiving **[Optional;** paid sick leave] **[Optional;** Paid Time Off] from your Employer.]

5. **SECTION 3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES**, is amended to add the following optional language:

**[Optional:**

**Cancer Treatment Benefit.** When you are undergoing chemotherapy or radiation treatment at the direction of a Physician Or Practitioner, your Beginning Date will be the **[Variable; first day]** of each period of Disability, **[Optional;** and the Allowable Period for Temporary Recovery And Separate Disabilities for the Cancer Treatment Benefit will be **[Variable; 14-180 days]]**.

**[Optional; Note:** If you have previously received STD Benefits for Disability resulting from the same cause or causes, the Beginning Date will not be retroactively adjusted to the first day.]]

6. **SECTION 1.6 INCONTESTABILITY**, is amended to add the following underlined words:

**1.6 INCONTESTABILITY**

When Evidence Of Insurability is required, the Company relies on the information provided. Any statement you make to obtain insurance is a representation and not a warranty. The Company may contest the validity of your insurance or reduce or deny a claim if:

- \* The information you provide contains a material misrepresentation;
- \* Your insurance would not have been approved if the Company had known the truth; and
- \* The Company has given you a copy of the written instrument signed by you which contains the material misrepresentation.

After your insurance has been in effect for two years, the Company will not use a misrepresentation to contest its validity or reduce or deny your claim for a Disability that begins after the two year period, unless the misrepresentation was fraudulent or material.

7. **SECTION 9.2 INCONTESTABILITY OF POLICY**, is amended to add the following underlined words:

**9.2 INCONTESTABILITY OF POLICY**

Any statement made by the Policyowner to obtain the Policy is a representation and not a warranty.

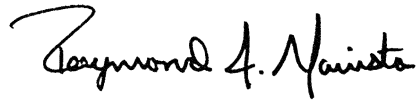
No material misrepresentation by the Policyowner will be used to deny a claim or to deny the validity of the Policy unless:

- \* The Policy would not have been issued if the Company had known the truth; and
- \* The Company has given the Policyowner a copy of a written instrument signed by the Policyowner which contains the material misrepresentation.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent or material misrepresentations.

The Northwestern Mutual Life Insurance Company

By

A handwritten signature in black ink, reading "Raymond A. Naisa". The signature is written in a cursive style with a large initial 'R' and 'N'.

Secretary

## AMENDMENT TO GROUP SHORT TERM DISABILITY INSURANCE CERTIFICATE FORM

Attached to and made a part of Group Certificate Form MN 992-STDC

Group Certificate Form MN 992-STDC is amended to provide an update to certificate language and to provide the following provisions for any Policyowner who negotiates the inclusion of such provisions into its Short Term Disability policy issued by us. The use of brackets ( [ ] ) indicate the language is optional or variable; optional language is either included or removed in entirety, while variable language shows possible language choices or the most common number range used within the brackets.

1. In order to provide loss of license language, **SECTION 2.3 DEFINITION OF DISABILITY**, is amended to add the following language:

**[Optional:**

Note: you are not Disabled from your Own Occupation merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license. The loss of a professional license, occupational license, or certification does not, in itself, constitute Disability.]

2. **SECTION 2.3 DEFINITION OF DISABILITY** is amended to add the following language:

**[Optional:**

**Own Occupation.** This is the job you are regularly performing for your Employer when Disability begins.]

**[Optional:**

**Material Duties.** These are the usual duties you perform in your regular job with your Employer.]

3. **SECTION 2.5 BENEFIT AMOUNTS**, is amended to add the following language:

**[Optional:**

**Return To Work Benefit.** The Return To Work Benefit will be paid in place of your STD Benefit, if you are working while Disabled. Your Return To Work Benefit equals your STD Benefit minus the amount of your **[Optional; Work Earnings,]** **[Optional; sick pay,]** **[Optional; annual or personal leave pay,]** **[Optional; severance pay,]** **[Optional; Paid Time Off,]** **[Optional; or other salary continuation,]** **[Optional; including donated amounts]** **[Optional; (but not vacation pay)]** **[Optional; or Paid Time Off)]** which, when added to your STD Benefit, exceeds **[Variable; 100%]** of your Predisability Earnings.



4. The following sections are amended to add Paid Time Off as follows:

**SECTION 4. EXCLUSIONS AND LIMITATIONS** of the **SPECIFICATIONS** section:

**4.2 LIMITATIONS**

**[Optional Limitation:**

\* **[Variable;** Paid Sick Leave;

**- Or -**

Paid Time Off]

**SECTION 2. BENEFITS**

**2.2 BENEFIT TERMS**

**[Optional;**

**Paid Time Off.** This is **[Variable;** e.g. vacation pay/sick pay/annual or personal leave pay] provided by your Employer.]

**SECTION 3. BENEFIT PROVISIONS**

**3.1 OTHER INCOME**

**Other Income.** The amounts below are Other Income:

**[Optional:**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer;

**- Or -**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;]

**SECTION 4. EXCLUSIONS AND LIMITATIONS**

**4.2 LIMITATIONS**

**[Optional:**

**Paid Sick Leave.** No benefits will be paid for any period when you are receiving **[Optional;** paid sick leave] **[Optional;** Paid Time Off] from your Employer.]

5. **SECTION 3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES**, is amended to add the following optional language:

**[Optional:**

**Cancer Treatment Benefit.** When you are undergoing chemotherapy or radiation treatment at the direction of a Physician Or Practitioner, your Beginning Date will be the **[Variable; first day]** of each period of Disability, **[Optional;** and the Allowable Period for Temporary Recovery And Separate Disabilities for the Cancer Treatment Benefit will be **[Variable; 14-180 days]]**.

**[Optional; Note:** If you have previously received STD Benefits for Disability resulting from the same cause or causes, the Beginning Date will not be retroactively adjusted to the first day.]]

6. **SECTION 1.6 INCONTESTABILITY**, is amended to add the following underlined words:

**1.6 INCONTESTABILITY**

When Evidence Of Insurability is required, the Company relies on the information provided. Any statement you make to obtain insurance is a representation and not a warranty. The Company may contest the validity of your insurance or reduce or deny a claim if:

- \* The information you provide contains a material misrepresentation;
- \* Your insurance would not have been approved if the Company had known the truth; and
- \* The Company has given you a copy of the written instrument signed by you which contains the material misrepresentation.

After your insurance has been in effect for two years, the Company will not use a misrepresentation to contest its validity or reduce or deny your claim for a Disability that begins after the two year period, unless the misrepresentation was fraudulent or material.

7. **SECTION 9.2 INCONTESTABILITY OF POLICY**, is amended to add the following underlined words:

**9.2 INCONTESTABILITY OF POLICY**

Any statement made by the Policyowner to obtain the Policy is a representation and not a warranty.

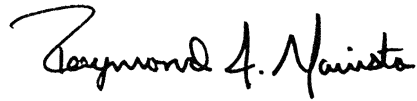
No material misrepresentation by the Policyowner will be used to deny a claim or to deny the validity of the Policy unless:

- \* The Policy would not have been issued if the Company had known the truth; and
- \* The Company has given the Policyowner a copy of a written instrument signed by the Policyowner which contains the material misrepresentation.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent or material misrepresentations.

The Northwestern Mutual Life Insurance Company

By

A handwritten signature in black ink, reading "Raymond A. Naisa". The signature is written in a cursive style with a large initial 'R' and 'N'.

Secretary

<i>SERFF Tracking Number:</i>	<i>NWST-128300321</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Northwestern Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.002 Short Term</i>
<i>Product Name:</i>	<i>MN 992-STD/0911</i>		
<i>Project Name/Number:</i>	<i>MN 992-STD/0911/MN 992-STD/0911</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved	07/02/2012
<b>Comments:</b>		
<b>Attachment:</b>		
AR READ CERT STD.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Application	Approved	07/02/2012
<b>Comments:</b>		
Using previously approved application NM-18 91-1658(6/87) approved on December 30, 1987.		
<b>Attachment:</b>		
DI APP.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> previously approved MN 992-STD and MN 992-STDC July 30, 1993	Approved	07/02/2012
<b>Comments:</b>		
<b>Attachment:</b>		
MN 992-STD-STDC.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> previously approved DOL	Approved	07/02/2012
<b>Comments:</b>		
<b>Attachment:</b>		
1-7-02 STD DOL ARKANSAS.pdf		

<b>Item Status:</b>	<b>Status</b>
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SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

**Satisfied - Item:** previously approved physician definition  
**Item Status:** Approved  
**Date:** 07/02/2012

**Comments:**

**Attachment:**

11-96 STD physician def ARKANSAS.pdf

**Satisfied - Item:** previously approved Time Of Payment  
**Item Status:** Approved  
**Status Date:** 07/02/2012

**Comments:**

**Attachment:**

1993 STD Time of Payment .pdf

**Satisfied - Item:** previously approved Allocation  
**Item Status:** Approved  
**Status Date:** 07/02/2012

**Comments:**

**Attachment:**

STD allocation of authority ARKANSAS.pdf

**Satisfied - Item:** Guaranty Association Notice  
**Item Status:** Approved  
**Status Date:** 07/02/2012

**Comments:**

**Attachment:**

AR Guaranty Association Notice.pdf

**Satisfied - Item:** Policy Info Notice  
**Item Status:** Approved  
**Status Date:** 07/02/2012

**Comments:**

**Attachment:**

SERFF Tracking Number: NWST-128300321 State: Arkansas  
Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term  
Product Name: MN 992-STD/0911  
Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

AR Policy Info.pdf

	Item Status:	Status Date:
<b>Satisfied - Item:</b> STD Sample Policy	Approved	07/02/2012
<b>Comments:</b>		
<b>Attachment:</b>		
STD Sample Policy.pdf		

# CERTIFICATION OF READABILITY

## STATE OF ARKANSAS

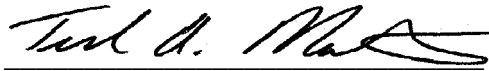
### Group Short Term Disability Insurance forms

### Flesch Reading Ease scores

STD Insurance Policy Amendment	MN992-STD/0911	54
STD Insurance Certificate Attachment	MN992-STDC/0911	54

I certify to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the minimum reading ease score and all other readability requirements of any applicable insurance laws and regulations in the state of Arkansas.

### **The Northwestern Mutual Life Insurance Company**



Signature

Ted Matchulat, Director Product Compliance

Name & Title

5/2/2012

Date

# Application for Group Disability Insurance

**Northwestern Mutual Life®**

Group Insurance Administration  
Post Office Box 2177  
Portland OR 97208-2177

Please Type or Print

## 1. Applicant

Full Legal Name of Organization (Exactly as it is to be shown in the policy)

\_\_\_\_\_

Street Address

City

State

Zip Code

## 2. Insurance Coverage Requested

☐ Long Term Disability (LTD)    ☐ Short Term Disability (STD)

## 3. Other Insurance

Does this insurance replace existing group insurance?

☐ No    ☐ Yes

Name of Insurance Carrier(s)

NOTE: If yes, submit a copy of each existing policy.

## 4. Requested Effective Date

\_\_\_\_/\_\_\_\_/\_\_\_\_ Actual Effective Date will be determined by Northwestern Mutual Life.

## 5. Initial Deposit

\$ \_\_\_\_\_ Minimum first month's premium is required.

## 6. Applicant Agreement

Applicant agrees that if the requested insurance is acceptable to The Northwestern Mutual Life Insurance Company under its current rules and practices, a policy will be issued in the policy language customarily used by Northwestern Mutual Life and will be effective on the date determined by Northwestern Mutual Life. **No agent has the authority to guarantee the acceptability of the requested insurance.**

Northwestern Mutual Life may issue separate policies if more than one coverage is requested in this application. The insurance, if approved, will be subject to The Northwestern Mutual Life Insurance Company's usual underwriting requirements including the Exclusions and Limitations in the Group Insurance Policy and, if applicable, Evidence of Insurability. Any insurance for which a person to be insured is required to submit satisfactory Evidence of Insurability will not become effective for that person until Northwestern Mutual Life sends written notice of approval to the Applicant. No premium will be collected or paid by the Applicant for such insurance until approved.

No brochures or other material describing coverage under the group insurance program will be distributed by the Applicant to any person to be insured without the prior written consent of Northwestern Mutual Life.

Premium rate quotations were based on the data submitted to Northwestern Mutual Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

The policy applied for is only available from The Northwestern Mutual Life Insurance Company. Only a Northwestern Mutual Life agent can be the agent of record for policies issued by Northwestern Mutual Life.

The consideration for any policy which may be issued is the payment of premiums plus the information contained in the Supplemental Information Worksheet which is incorporated herein by reference. Payment of premium after receipt of the policy is acceptance of the policy terms.

Signature of Applicant's Representative

Title

Signature of Licensed Agent

Date

Place



## FRAUD NOTICES

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

For use in ARKANSAS, KENTUCKY, NEW MEXICO, AND OHIO: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

For use in COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For use in FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony in the third degree.

For use in MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For use in NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for such violation.

For use in PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### **Terms of Receipt (Please read carefully).**

*If the requested insurance is acceptable to The Northwestern Mutual Life Insurance Company under its current rules and practices, a policy will be issued in the policy language customarily used by Northwestern Mutual Life and will be effective on the date determined by Northwestern Mutual Life. No agent has the authority to guarantee the acceptability of the requested insurance.*

*Northwestern Mutual Life may issue separate policies if more than one coverage is requested in this application. The insurance, if approved, will be subject to The Northwestern Mutual Life Insurance Company's usual underwriting requirements including the Exclusions and Limitations in the Group Insurance Policy and, if applicable, Evidence of Insurability. Any insurance for which a person to be insured is required to submit satisfactory Evidence of Insurability will not become effective for that person until Northwestern Mutual Life sends written notice of approval to the Applicant. No premium will be collected or paid by the Applicant for such insurance until approved.*

*No brochures or other material describing coverage under the group insurance program will be distributed by the Applicant to any person to be insured without the prior written consent of Northwestern Mutual Life.*

*Premium rate quotations were based on the data submitted to Northwestern Mutual Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.*

*The policy applied for is only available from The Northwestern Mutual Life Insurance Company. Only a Northwestern Mutual Life agent can be the agent of record for policies issued by Northwestern Mutual Life.*

*The consideration for any policy which may be issued is the payment of premiums plus the information contained in the Supplemental Information Worksheet which is incorporated herein by reference. Payment of premium after receipt of the policy is acceptance of the policy terms.*



**Northwestern Mutual®**

The Northwestern Mutual Life Insurance Company

### **Receipt For Initial Deposit**

Received from \_\_\_\_\_, an initial deposit of \$\_\_\_\_\_ \* in connection with the Application for Group Disability Insurance bearing the same date as this Conditional Receipt.

Date \_\_\_\_\_ Place \_\_\_\_\_

***This receipt is subject to the terms and conditions stated above.***

Received By \_\_\_\_\_

Licensed Agent \_\_\_\_\_

**\* All premium checks must be made payable to The Northwestern Mutual Life Insurance Company.**

**Do not make check payable to the agent or leave payee blank.**



**ARKANSAS  
INSURANCE  
DEPARTMENT**

400 University Tower Building  
1123 South University Ave.  
Little Rock, Arkansas 72204

Lee Douglass  
Insurance Commissioner

501-686-2900

July 30, 1993

Ms. Deborah L. Huff, JD  
Compliance Analyst  
Group Legal Department  
Group Insurance Administration  
Northwestern Mutual Life  
P.O. Box 2177  
Portland, OR 97208-2177

COMPLIANCE  
AUG 03 1993

RE: MN992-LTD/MN992-LTDC  
MN992-STD/MN992-STD  
MN992-CONV/MN992-CONVC

Dear Ms. Huff:

This is to advise that our Department has reopened the above files which were disapproved by our Department.

Effective on this date, July 30, 1993, the above filings have been approved with the changes to the Allocation of Authority and the Time of Payment of claims.

Sincerely,

A handwritten signature in cursive script that reads "Rosalind D. Minor".

Rosalind D. Minor  
Rate and Form Analyst  
Life and Health Division

cc: John Shields  
Cindy Uhrynowicz

RDM

Group Insurance Administration  
Post Office Box 2177  
Portland OR 97208-2177  
Telephone 503/226-0400

Northwestern  
Mutual Life®

APPROVED

JUL 30 1993

July 16, 1993

Insurance Commissioner  
State of Arkansas

RECEIVED

JUL 19 1993

COMPLIANCE

AUG 03 1993

Mr. John Shields, Director  
Life and Health Division  
Arkansas Insurance Department  
400 University Tower Building  
1123 South University Avenue  
Little Rock AR 72204

LIFE AND HEALTH  
ARKANSAS INSURANCE DEPARTMENT

RE: MN992-LTD/MN992-LTDC  
MN992-STD/MN992-STDC  
MN992-CONV/MN992-CONVC

A handwritten signature in black ink, appearing to be "OK" followed by a stylized name or initials.

Dear Mr. Shields,

I appreciate your taking the time to speak with me this morning regarding the above referenced filings. As I mentioned, we have been in negotiations with Cindy Uhrynowycz of your Legal Department, regarding the Allocation Of Authority provision we have incorporated into our contracts.

As I understand Ms. Uhrynowicz has left the office on maternity leave, please allow me to recap the resolution of our negotiations per our July 2, 1993, conference call between Ms. Uhrynowycz, our staff attorney Phillip David and myself:

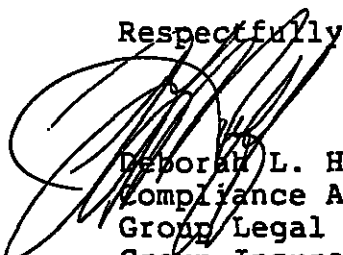
Ms. Uhrynowycz had been in contact with Don Switzer during your absence and they determined that if we would remove the last sentence of the Allocation Of Authority provision the language would be approved by the Department. We indicated that we needed to present this for Company approval prior to committing the contract language to this change. I received Company authority this morning and have enclosed the replacement pages for the LTD and STD policies and certificates. Additionally, I have created a state variation policy rider and certificate attachment for the LTD Conversion product, which was retroactively disapproved pending the same change.

As this was the last outstanding issue yet to be resolved on these product filings, I hope this change has brought our negotiations to a successful close. I look forward to receiving the Department's approval. DeLone Cates is the policy analyst on these filings, although since we have been

corresponding with Ms. Uhrynowicz, I do not know if she is aware of what has transpired. I hope that we have not inadvertently caused her any problems as this was not our intent. She has always been very pleasant to work with.

I am pleased that you have returned from your medical leave, and wish you only the best in your recovery. Please feel free to contact me if you have any questions concerning the above material or need anything further for approval.

Respectfully Submitted,



Deborah L. Huff, JD  
Compliance Analyst  
Group Legal Department  
Group Insurance Administration  
(503) 321-7847

**GROUP INSURANCE CERTIFICATE****NORTHWESTERN MUTUAL LIFE**

HOME OFFICE: 720 East Wisconsin Ave., Milwaukee WI 53202  
GROUP INSURANCE ADMINISTRATION: PO Box 2177, Portland OR 97208

The Northwestern Mutual Life Insurance Company certifies that you will be insured under the Policy described below during the time, in the manner, and for the amounts provided in the Policy.

**DISAPPROVED**  
*John H. ...*  
Chairman of the Board  
DEC 08 1992

---

POLICY NUMBER	SAMPLE
NAME OF POLICYOWNER	ABC Company
TYPE OF COVERAGE	Group Short Term Disability
POLICY EFFECTIVE DATE	January 1, 1992
POLICY ISSUED IN	the state of Arkansas

---

**Important -- Please Read This:**

A Policy has been issued to the Policyowner. Your coverage under that Policy is shown in this Certificate. If your coverage is changed by an amendment to the Policy, the Company will provide the Policyowner with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

Please read this Certificate carefully. This Certificate has a Guide To Policy Provisions to help you find specific provisions.

The terms "you" and "your" refer to the insured Member. The term "the Company" refers to Northwestern Mutual Life. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear capitalized and in boldface type.

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## **SPECIFICATIONS**

This section contains many of the features of your short term disability (STD) insurance. Other provisions, including exclusions, limitations, and Other Income, appear in other sections. Please refer to the text of each section for full details. The Guide To Policy Provisions and Index Of Defined Terms help locate sections and definitions.

---

### **GENERAL INFORMATION**

<b>Policy Number:</b>	<b>SAMPLE</b>
<b>Policyowner:</b>	<b>ABC Company</b>
<b>Employer:</b>	<b>ABC Company XYZ Affiliate</b>
<b>Policy Effective Date:</b>	<b>January 1, 1992</b>
<b>Policy Issued In:</b>	<b>Arkansas</b>

---

### **SECTION 1. BECOMING INSURED**

**To become insured you must:**

- \* Be a Member;
- \* Complete your Eligibility Waiting Period For Insurance; and
- \* Meet the other requirements in Section 1. Becoming Insured.

**Definition of Member:**  
**[variable; Employer determined]**

- \* An active employee of the Employer;
- \* A citizen or resident of the United States or Canada; and
- \* Regularly working 30 or more hours per week for the Employer;

**You are not a Member if you are:**

- \* A temporary or seasonal employee;  
or
- \* A full time member of the armed forces of any country.



**Eligibility Waiting  
Period For Insurance:**  
[variable; Employer determined]

This is the period you must be a Member before you become eligible for insurance.

You meet the Eligibility Waiting Period For Insurance on the later of the Policy Effective Date; and the first day after 365 consecutive days as a Member.

**Evidence Of Insurability:**

Required for:

[Optional, for Contributory only:  
\* Late application for Contributory insurance;]  
\* Reinstatements if required; and  
\* Members eligible but not insured under the Prior Plan.

**Member Contributions:**  
[variable;

Noncontributory. The Policyowner or Employer pays the entire premium for your insurance.

-Or-

Contributory. You pay all or part of the premium for your insurance.

---

## **SECTION 2. BENEFITS**

### **2.3 BENEFIT TERMS**

**Beginning Date:**

[variable; e.g. 31st] day of each period of Disability caused by accidental Injury.

[variable; e.g. 31st] day of each period of Disability caused by Sickness or Pregnancy.

**Maximum Benefit**

[variable; ranges from 40% to 75%] of your Predisability Earnings not to exceed:

\* [variable; ranges from \$50 to \$3,500] if Preexisting Condition

Limitation applies; or

\* [variable; ranges from \$50 to \$5,000] if Preexisting Condition Limitation does not apply.

**Minimum Benefit:** [variable; ranges from \$0 to \$25].

**Maximum Benefit Period** [variable; ranges from 15 days to 104 weeks]

**Predisability Earnings:** Based on last full day of Active Work.

**Earnings Period:** The preceding [variable; e.g. 52, 104, or 156] weeks.

## **2.4 DEFINITION OF DISABILITY**

[Optional:  
**Partial Disability:** Covered.

**Partial Disability  
Income Percentage:** [variable; ranges from 40% to 80%]  
of your Predisability Earnings.]

## **2.5 BENEFIT AMOUNTS**

**STD Benefit:** Your Maximum Benefit minus your  
Other Income.

[Optional:  
**Return To Work  
50% Offset Benefit:** Your STD Benefit minus one-half  
your Work Earnings.]

---

## **SECTION 4. EXCLUSIONS AND LIMITATIONS**

**4.1 EXCLUSION:** [Optional Exclusion:  
\* Work Related;]  
\* Intentionally self-inflicted  
injury; and  
\* War.

**4.2 LIMITATIONS** \* Physician Or Practitioner;  
[Optional Limitation:  
\* Occupational Benefits;]  
[Optional Limitation:  
\* Paid Sick Leave;]  
[Optional Limitation:  
\* Working; and]

**[Optional Limitation:  
\* Preexisting Condition]**

**[Optional:  
Preexisting Condition  
Period:**

The [variable; ranges from 30 to 365]-day period just before the date your insurance becomes effective.

**Limitation Period:**

The first [variable; 12, 24] months you are insured.]

---

## **SECTION 5. TERMINATION**

### **5.1 WHEN INSURANCE ENDS**

**Leave of Absence Period:** Insurance is continued while on a leave of absence scheduled to last [30] days or less.

---

## **SECTION 1. BECOMING INSURED**

[variable language]

- if insurance is Noncontributory -

### **1.1 INITIAL EFFECTIVE DATE**

You are eligible for insurance if you are a Member who has completed the Eligibility Waiting Period For Insurance shown in the Specifications. Subject to the Active Work Requirement, your Noncontributory insurance will become effective as determined in this section.

**Evidence Of Insurability Not Required.** Insurance not subject to Evidence Of Insurability will become effective on the date you meet the Eligibility Waiting Period For Insurance.

**Evidence Of Insurability Required.** Insurance subject to Evidence Of Insurability will become effective on the date the Company approves your Evidence Of Insurability.

**Evidence Of Insurability.** When required you must:

- \* Complete the forms required by the Company;
- \* Sign the forms which allow the Company to obtain information about you;
- \* Provide, at your expense, other information the Company may reasonably require for determining your insurability; and
- \* Undergo a physical examination, if required by the Company [Optional language: ", which may include blood testing"].

- if insurance is Contributory -

### **1.1 INITIAL EFFECTIVE DATE**

You are eligible for insurance if you are a Member who has completed the Eligibility Waiting Period For Insurance shown in the Specifications. To become insured for Contributory insurance you must apply in writing and agree to pay premiums. Subject to the Active Work Requirement, your Contributory insurance will become effective as determined in this section.

**Evidence Of Insurability Not Required.** Insurance not subject to Evidence Of Insurability will become effective on:

- \* The date you meet the Eligibility Waiting Period For Insurance, if you apply on or before that date; or

- \* The date you apply, if you apply within 31 days after the date you meet the Eligibility Waiting Period For Insurance.

**Late Application.** Evidence Of Insurability is required if you apply for Contributory insurance more than 31 days after the date you meet the Eligibility Waiting Period For Insurance.

**Evidence Of Insurability Required.** Insurance subject to Evidence Of Insurability will become effective on the date the Company approves your Evidence Of Insurability.

**Evidence Of Insurability.** When required you must:

- \* Complete the forms required by the Company;
- \* Sign the forms which allow the Company to obtain information about you;
- \* Provide, at your expense, other information the Company may reasonably require for determining your insurability; and
- \* Undergo a physical examination, if required by the Company [Optional language: ", which may include blood testing"].

## **1.2 DELAYED EFFECTIVE DATE**

If you do not meet the Active Work Requirement, the effective date of your insurance is delayed. Delayed insurance becomes effective on the day after you complete one full day of Active Work.

## **1.3 ACTIVE WORK REQUIREMENT**

The Active Work Requirement is met if you are a Member who is Actively At Work on the day before the scheduled effective date of your insurance. It is also met if you:

- \* Are capable of Active Work on that day, but are absent due to vacation, holiday, or scheduled day off; and
- \* Were Actively At Work on the last scheduled work day before the absence.

**Actively At Work and Active Work.** This means you are performing the material duties of your Own Occupation at your Employer's usual place(s) of business.

#### **1.4 REPLACEMENT COVERAGE**

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Policy, you do not have to meet the Eligibility Waiting Period For Insurance shown in the Specifications. [Optional, included if insurance is Contributory: If you were eligible for insurance under the Prior Plan for more than 31 days but were not insured, you must provide satisfactory Evidence Of Insurability to become insured under the Policy.]

**Prior Plan.** This means your Employer's group short term disability insurance plan in effect on the day before the effective date of your Employer's coverage under the Policy and which is replaced by the Policy.

#### **1.5 INCREASED INSURANCE**

An increase in your insurance does not become effective until you meet the Active Work Requirement. However, if you meet the Active Work Requirement while Disabled or during a period of Temporary Recovery, you will not qualify for any increase in insurance.

#### **1.6 INCONTESTABILITY**

When Evidence Of Insurability is required, the Company relies on the information provided. Any statement you make to obtain insurance is a representation and not a warranty. The Company may contest the validity of your insurance or reduce or deny a claim if:

- \* The information you provide contains a misrepresentation;
- \* Your insurance would not have been approved if the Company had known the truth; and
- \* The Company has given you a copy of the written instrument signed by you which contains the misrepresentation.

After your insurance has been in effect for two years, the Company will not use a misrepresentation to contest its validity or reduce or deny your claim for a Disability that begins after the two year period, unless the misrepresentation was fraudulent.

## **SECTION 2. BENEFITS**

### **2.1 INSURING CLAUSE**

Benefits become payable for your Disability only if:

- \* You become Disabled while insured under the Policy;
- \* You are under the ongoing care of a Physician Or Practitioner;
- \* Your Disability results from an Injury, Sickness, or Pregnancy;
- \* You give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date;
- \* Your Disability is not excluded under Section 4. Exclusions And Limitations; and
- \* You meet all other terms of the Policy.

### **2.2 BENEFIT TERMS**

**Beginning Date.** This is the date on which benefits begin to accrue after you become Disabled. Benefits are not payable for the time you are Disabled before the Beginning Date. See Specifications.

**Maximum Benefit.** Your Maximum Benefit is shown in the Specifications.

**Minimum Benefit.** Your Minimum Benefit is shown in the Specifications.

**Maximum Benefit Period.** This is the longest period for which benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins on the Beginning Date. No STD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See Specifications

[variable; e.g.

**Predisability Earnings.** Your Predisability Earnings for each uninterrupted period of Disability will be the Predisability Earnings in effect on the date shown in the Specifications. Any change in your earnings after that date will not affect your Predisability Earnings.

**Sole Proprietors, Partners, and S-Corporation Shareholders.** Predisability Earnings means your average weekly compensation from your Employer during the Employer's prior tax year. Your

average weekly compensation is determined by adding the following amounts as reported on Schedule C, Schedule K-1, Form W-2, or S-Corporation federal income tax return, and dividing by 52:

- \* Your net profit from business;
- \* Your ordinary income from trade or business activity(ies);
- \* Your guaranteed payments, if you are a partner; and
- \* Your compensation (as an officer), salary, and wages, if you are an S-corporation shareholder.

If you were not a sole proprietor, partner, or shareholder of the Employer during the entire prior tax year, your Predisability Earnings will be your average weekly compensation for your period as a sole proprietor, partner, or shareholder.

**All Other Members.** Predisability Earnings means your weekly rate of earnings from your Employer, including:

- \* Commissions averaged over the Earnings Period shown in the Specifications or over the period of your employment if less than the Earnings Period; and
- \* Shift differential pay.

Predisability Earnings does not include:

- \* Bonuses;
- \* Overtime pay; and
- \* Any other extra compensation.

If you are paid on an annual contract basis, your weekly rate of earnings is based on one-fifty second (1/52nd) of your annual contract salary.

If you are paid hourly, your weekly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week, but not more than 40 hours. If you do not have regular work hours, your weekly rate of earnings is based on the average number of hours you worked per week during the preceding 52 weeks (or during your period of employment if less than 52 weeks), but not more than 40 hours.

**All Members.** Predisability Earnings includes contributions you make through a salary reduction agreement with your Employer to:



- \* An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), or 457 deferred compensation arrangement;
- \* An executive, nonqualified deferred compensation arrangement; or
- \* An IRC Section 125 plan.

Predisability Earnings does not include your Employer's contributions on your behalf to any deferred compensation arrangement, pension plan, or benefit plan.]

**Injury.** This is an injury to your body.

**Physician Or Practitioner.** This is a licensed medical professional, other than yourself, diagnosing and treating you within the scope of the license.

**Pregnancy.** This is your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

**Sickness.** This is your sickness, illness, or disease.

## 2.3 DEFINITION OF DISABILITY

[variable language]

- if Partial Disability is not covered -

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation.

- if Partial Disability is covered -

You are Disabled if you meet either of the following definitions:

- \* Definition of Disability; or
- \* Definition of Partial Disability.

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation.

**Definition Of Partial Disability.** You are Partially Disabled if you are working for your Employer but, as a result of Sickness, Injury, or Pregnancy, are unable to earn more than the Partial Disability Income Percentage shown in the Specifications.

## **2.4 WORKING WHILE DISABLED**

You may accrue days toward the Beginning Date while working if you are Disabled.

During the Maximum Benefit Period, benefits are payable while you are working if you are Disabled. However, one-half of your Work Earnings will be used to reduce your benefit as shown in 2.5 Benefit Amounts.

## **2.5 BENEFIT AMOUNTS**

[Optional:

The benefit payable during your Disability will be one of the benefits described in this section, subject to the Maximum Benefit and Minimum Benefit shown in the Specifications.]

**STD Benefit.** This is your Maximum Benefit minus your Other Income. Your Maximum Benefit is shown in the Specifications.

[Optional:

**Return To Work 50% Offset Benefit.** This is your STD Benefit minus one-half of your Work Earnings.

**Work Earnings.** This is your gross weekly earnings from work you perform for your Employer while Disabled. Your earnings will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than weekly, the Company will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, the Company will use a reasonable one.]

[Optional:

**Daily Hospital Benefit.** The Company will pay you a Daily Hospital Benefit equal to one-seventh of your benefit for each day prior to your Beginning Date that you are confined in a Hospital for at least four hours.

The Daily Hospital Benefit will not be paid for days you are confined to a Hospital after your Beginning Date.

- Or -

**First Day Hospital Benefit.** If you are confined in a Hospital for at least four hours prior to your Beginning Date, the following will apply:

- \* The unaccrued days toward your Beginning Date will be waived;
- \* Benefits will become payable on the first day of Hospital confinement;

\* Your Maximum Benefit Period will begin on the date benefits become payable; and

\* You must be under the ongoing care of a Physician Or Practitioner during your Hospital confinement.]

[Optional:

Hospital. This is a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.]

When a Disability lasts for a part of a week, 1/7th of the full benefit will be payable for each day you are Disabled.

[Optional:

#### **2.6 WAIVER OF PREMIUM**

The Company will waive premiums for your insurance while benefits are payable to you.]

#### **2.7 ASSIGNMENT**

The rights and benefits under the Policy are not assignable.

#### **2.8 CONTINUATION OF BENEFITS**

Your right to receive benefits for a period of Disability which begins while you are insured will not be affected by:

- \* Termination of the Policy after you become Disabled;
- \* Termination of your insurance while the Policy remains in force; or
- \* Any amendment to the Policy approved after the date you become Disabled.

#### **2.9 WHEN BENEFITS END**

Your benefits end automatically on the earliest of:

- \* The date you are no longer Disabled;
- \* The date your Maximum Benefit Period ends;
- \* The date you die; and

[Optional; included if LTD policy is also in force:

- \* The date long term disability benefits become payable to you under a group LTD insurance policy issued by the Company.]

### SECTION 3. BENEFIT PROVISIONS

#### 3.1 OTHER INCOME

Other Income. The amounts below are Other Income:

[Optional:

- \* The amount of your sick pay or other salary continuation (but not vacation pay) [variable; paid, payable] to you by your Employer;

- Or -

- \* The amount of your sick pay or other salary continuation (but not vacation pay) [variable; paid, payable] to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;]

[Optional:

- \* Any amount you receive or are eligible to receive as a result of your disability from any state disability income benefit law or similar law;]

[Optional:

- \* Any amount you, your spouse or your children receive or are eligible to receive as a result of your disability or retirement under the Federal Social Security Act. Early retirement benefits payable prior to normal retirement age under the act will not be used to reduce the amount of your benefit unless they are actually received;]

[Optional, added when insurance is 24-hour coverage:

- \* Any amount you receive or are eligible to receive as a result of your disability under a Worker's Compensation Act or similar law, including amounts for partial or total disability, whether permanent or temporary;] and

[Optional:

- \* Any amount you receive or are eligible to receive due to compromise, settlement, or other method as a result of a claim for any Other Income, whether disputed or undisputed.]

### **3.2 RULES FOR OTHER INCOME**

**Weekly Equivalents.** Each week the Company will determine your benefit using the Other Income attributable to the same weekly period, even if you actually receive the Other Income in another week.

If you are paid Other Income in a lump sum or by a method other than weekly, the Company will determine your benefit using a prorated amount. The Company will use the period of time to which the Other Income applies. If no period of time is stated, the Company will use a reasonable one.

**Your Duty To Pursue Other Income.** You must pursue Other Income for which you may be eligible. The Company may ask for written documentation of your pursuit of Other Income. You must provide satisfactory documentation within 60 days after the Company mails you a request. Otherwise, the Company may reduce your benefits by the amount the Company estimates you would be eligible to receive upon proper pursuit of the Other Income. You must notify the Company of the amount of the Other Income when it is approved.

**Overpayment Of Claim.** You must immediately repay the Company any overpayment of your claim. The Company will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by the Company. You will not receive any benefits until the Company has been repaid in full. In the meantime, any benefits paid, including the Minimum Benefit, will be applied to reduce the amount of the overpayment. The Company may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after the Company first mails you notice of the amount of the overpayment.

### **3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES**

You may temporarily recover from your Disability, and then become Disabled again from the same cause or causes, without having to start accruing days toward a new Beginning Date.

**Temporary Recovery.** This means you cease to be Disabled for no more than the following allowable period:

**Allowable Period.** The allowable period of recovery during the Maximum Benefit Period is 14 days.

**Effect Of Your Temporary Recovery:**

- \* The Predisability Earnings used to determine your benefit will not change;

- \* The period of Temporary Recovery will not count toward your Maximum Benefit Period;
- \* No benefits will be payable for the period of Temporary Recovery; and
- \* Except as stated above, the provisions of the Policy will be applied as if there had been no interruption of your Disability.

**Separate Disabilities.** Each time you cease to be Disabled for more than the allowable period, a new Maximum Benefit Period applies.

### **3.4 EXTENDED DISABILITY**

If a period of Disability is extended by a new cause while benefits are payable, benefits will continue while you remain Disabled. However:

- \* Benefits will not continue beyond the end of the original Maximum Benefit Period; and
- \* Section 4. Exclusions And Limitations will apply to the new cause of Disability.

### **3.5 MISSTATEMENT OF AGE**

If a person's age has been misstated, the Company will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

- \* The amount of insurance based on the correct age; and
- \* The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

## **SECTION 4. EXCLUSIONS AND LIMITATIONS**

### **4.1 EXCLUSIONS**

You are not covered for a Disability:

[Optional, applies to non-occupational coverage:

- \* Arising out of or in the course of any employment for wage or profit;]
- \* Caused or contributed to by an intentionally self-inflicted injury, while sane or insane; or

\* Caused or contributed to by War or any act of War.

War. This is declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

#### 4.2 LIMITATIONS

**Physician Or Practitioner.** You must be under the ongoing care of a Physician Or Practitioner during your Disability. No benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician Or Practitioner.

[Optional, applies to non-occupational coverage:

**Occupational Benefits.** No benefits will be paid for any period when you are eligible to receive benefits under a workers' compensation law or similar law. If your claim for these benefits is accepted, compromised, or settled (whether disputed or undisputed), you must repay the Company for the full amount of any payments the Company makes to you while your claim for occupational benefits is pending.]

[Optional:

**Paid Sick Leave.** No benefits will be paid for any period when you are receiving paid sick leave from your Employer.]

[Optional:

**Working.** No benefits will be paid for any period when:

- \* You are working for wage or profit for any employer other than your Employer; or
- \* You are self-employed.]

[Optional:

**Preexisting Condition.** Your benefit will be limited as shown in the Specifications if your Disability is caused or contributed to by a Preexisting Condition. However, this limitation will not apply if you meet both of the following on the date you become Disabled:

- \* You have been continuously insured under the Policy for the entire Limitation Period shown in the Specifications; and
- \* You have been Actively At Work for at least one full day after the end of the Limitation Period.

**Preexisting Condition.** This is a mental or physical condition for which you have consulted a Physician Or Practitioner, received medical treatment or services, or taken prescribed drugs or medications at any time during the Preexisting Condition

Period shown in the Specifications.]

#### 4.3 CONTINUITY OF COVERAGE

The Continuity of Coverage provision changes other provisions found in the Policy.

**Waiver Of Active Work Requirement.** If you were insured under the Prior Plan on the day before the effective date of your Employer's insurance under the Policy, you can become insured on the effective date of your Employer's insurance without meeting the Active Work Requirement.

The benefit payable for a period of continuous Disability beginning before you meet the Active Work Requirement will be:

- \* The weekly benefit payable under the terms of the Policy; reduced by
- \* Any benefits payable under the Prior Plan.

There is no Minimum Benefit if there is a reduction because of benefits payable under the Prior Plan.

**Waiver Of Preexisting Conditions.** If your Disability is subject to the Preexisting Condition Limitation, benefits will not be limited if:

- \* You were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Policy;
- \* You became insured under the Policy when your insurance under the Prior Plan ceased;
- \* You were continuously insured under the Policy from the effective date of your insurance under the Policy through the date you became Disabled from the Preexisting Condition; and
- \* Benefits would have been payable under the Prior Plan if it had remained in force, taking into account the preexisting condition limitation, if any, of the Prior Plan.

Payment of your benefit will be made under the terms of the Policy.



## **SECTION 5. TERMINATION**

### **5.1 WHEN INSURANCE ENDS**

Your insurance ends automatically on the earliest of:

[Optional, included when insurance is Contributory:

\* The date the last period ends for which you made a premium contribution;]

\* The date the Policy terminates;

\* The date your employment terminates; and

\* The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued during the following periods, unless it ends on one of the dates shown above:

(1) While you are receiving from your Employer at least the amount of Predisability Earnings in effect immediately before you ceased to be a Member;

(2) While you are Disabled before the Beginning Date and while benefits are payable; or

(3) During a leave of absence if continuation of your insurance under the Policy is required by the state-mandated family or medical leave act or law.

(4) During any other leave of absence approved by your Employer in advance and in writing and scheduled to last the period shown in the Specifications.

[Optional, included for school groups:

If you cease to be a Member because of a school break or vacation, your insurance will be continued during that period.]

### **5.2 REINSTATEMENT OF INSURANCE**

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

\* If your insurance ends because you cease to be a Member, and if you become a Member again within 90 days, the Eligibility Waiting Period For Insurance will be waived;

[Optional; included when insurance is Contributory:

\* If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again;]

- \* If your insurance ends because you are on a state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the state-mandated family or medical leave act or law; and
- \* The Preexisting Condition Limitation will be applied as if there had been no break in your insurance in the following instances:
  - (1) If you become insured again within 90 days.
  - (2) If required by a state-mandated family or medical leave act or law and you become insured again immediately following the period allowed under the family or medical leave act or law.

## **SECTION 6. CLAIMS**

### **6.1 FILING A CLAIM**

Claims should be filed on the Company's forms. If you do not receive the Company's forms within 15 days after you ask for them, you may submit your claim in a letter to the Company. The letter should include the date your disability began, and the cause and nature of your disability.

### **6.2 PROOF OF LOSS**

You must give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date. If you cannot do so, you must give it to the Company as soon as reasonably possible, but not later than one year after that 90 day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

**Proof Of Loss.** This means written proof that you are Disabled and entitled to benefits. Proof Of Loss must be provided at your expense.

### **6.3 DOCUMENTATION**

At your expense, you must submit completed claims statements, your signed authorization for the Company to obtain information, and any other items the Company may reasonably require in support of your claim. If you do not provide the documentation within 60 days after the Company mails you a request, your claim may be denied.

#### **6.4 TIME OF PAYMENT**

The Company will pay benefits within 60 days after you provide satisfactory Proof Of Loss. Benefits will be paid at the end of each week you qualify for them.

#### **6.5 PAYMENT OF CLAIM**

Benefits will be paid to you. Benefits remaining unpaid at your death will be paid to your estate.

#### **6.6 INVESTIGATION OF CLAIM**

The Company may investigate your claim at any time. At its own expense, the Company may have you and your financial records examined as often as is reasonably necessary. This will be done by specialists of the Company's choice. The Company may deny or suspend benefits if you fail to attend an examination or cooperate with the examiner.

#### **6.7 NOTICE OF DECISION ON CLAIM**

You will receive a written decision on your claim within a reasonable time after the Company receives your claim.

If you do not receive the Company's decision within 90 days after the Company receives your claim, you will have an immediate right to request a review as if your claim had been denied.

If the Company denies any part of your claim, you will receive a written notice of denial containing:

- \* The reasons for the decision;
- \* Reference to the parts of the Policy on which the decision is based;
- \* A description of any additional information needed to support your claim; and
- \* Information concerning your right to a review of the decision.

#### **6.8 REVIEW PROCEDURE**

You may request in writing a review of a denial of all or part of your claim within 60 days after you receive notice of the denial.

When you request a review, you may send the Company written comments or other items to support your claim. You may review any non-privileged information that relates to your request for

review.

The Company will review your claim promptly after receiving your request. The Company will send you a notice of its decision within 60 days after receiving your request, or within 120 days if special circumstances require an extension. The Company will state the reasons for its decision and refer you to the relevant parts of the Policy.

#### **6.9 TIME LIMITS ON LEGAL ACTIONS**

No action at law or in equity may be brought until 60 days after you have given the Company Proof Of Loss. No such action may be brought more than three years after the earlier of:

- \* The date the Company receives Proof Of Loss; and
- \* The end of the period within which Proof Of Loss is required to be given.

#### **SECTION 7. ALLOCATION OF AUTHORITY**

Except for those functions which the Policy specifically reserves to the Policyowner, the Company has full and exclusive authority to control and manage the Policy, to administer claims, and to interpret the Policy and resolve all questions arising in the administration, interpretation, and application of the Policy.

The Company's authority includes, but is not limited to:

- \* The right to resolve all matters when a review has been requested;
- \* The right to establish and enforce rules and procedures for the administration of the Policy and any claim under it;
- \* The right to determine:
  - (1) Your eligibility for insurance;
  - (2) Your entitlement to benefits;
  - (3) The amount of benefits payable to you;
  - (4) The sufficiency and the amount of information the Company may reasonably require to determine 1, 2, or 3 above.

Subject to the review procedures of the Policy, any decision the Company makes in the exercise of the Company's authority is

conclusive and binding.

## GROUP INSURANCE POLICY

NORTHWESTERN MUTUAL LIFE

HOME OFFICE: 720 East Wisconsin Ave., Milwaukee WI 53202  
GROUP INSURANCE ADMINISTRATION: PO Box 2177, Portland OR 97207

POLICY NUMBER

SAMPLE

NAME OF POLICYOWNER

ABC Company

TYPE OF COVERAGE

Group Short Term

POLICY EFFECTIVE DATE

January 1, 1992

**DISAPPROVED**

DEC 08 1992

**INSURANCE COMMISSIONER  
STATE OF ARKANSAS**

The Northwestern Mutual Life Insurance Company agrees to pay the benefits provided by the Policy, in accordance with the provisions of the Policy.

The consideration for the Policy is the application of the Policyowner and the payment by the Policyowner of premiums as provided herein.

The Policy is issued for the Initial Rate Guaranty Period shown in the Specifications. The Policy may be renewed for successive renewal periods by the payment of the Premium on each renewal date, provided the number of persons insured on each renewal date is neither less than the Minimum Participation Number nor less than the Minimum Participation Percentage shown in the Specifications. The length of successive renewal periods will be determined by the Company, but will not be less than 12 months.

For purposes of effective dates and ending dates under the Policy, all days begin and end at 12:01 A.M. Standard Time at the Policyowner's address.

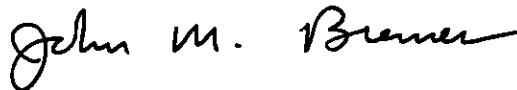
All provisions on this and the following pages are part of the Policy. The terms "you" and "your" refer to the insured Member. The term "the Company" refers to Northwestern Mutual Life. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear capitalized and in boldface type.

The Northwestern Mutual Life Insurance Company

By



Chairman and C.E.O.



Secretary

STATE OF ARKANSAS  
REQUIRED POLICY INFORMATION

Insurance Department  
Address

Arkansas Insurance Department  
Consumer Services Division  
Third and Cross Streets  
Little Rock, Arkansas 72201

Telephone Number

(800) 852-5494

Name and Address of the  
Insurance Company

The Northwestern Mutual Life Insurance Company  
Group Insurance Administration  
Post Office Box 2177  
Portland, Oregon 97208-2177

Telephone Number

(800) 378-4665

Name, Address, and  
Telephone Number of the  
Agent or Broker

Mr. John Doe  
123 Main Street  
Little Rock, AR  
(123) 456-7890

**SUMMARY OF COVERAGE, LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT**

**ARKANSAS LIFE AND DISABILITY  
INSURANCE GUARANTY ASSN.  
300 UNIVERSITY TOWER BLDG  
12TH & UNIVERSITY  
LITTLE ROCK, AR 72204**

**ARKANSAS INSURANCE DEPT.  
400 UNIVERSITY TOWER BLDG  
12TH & UNIVERSITY  
LITTLE ROCK, AR 72204**

Residents of Arkansas who purchase life or disability insurance policies and annuity contracts should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association ("Association"). The Association was established under the provisions of the Arkansas Life and Disability Insurance Guaranty Act ("Act"). The purpose of this Association is to assure that policyholders will be protected, within the limits set forth in the Act, in the event a member insurer becomes financially unable to meet its contractual obligations. If this should happen, the Association will assess its other member insurers for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. The protection provided through the Association is limited. This protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable from which to buy insurance.

Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

**Persons Covered**

Generally, individuals will be protected by the Association if they live in this state and hold a life or disability insurance contract or certificate, or an annuity contract, as defined in the Act, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**Limits on Amount of Coverage**

The Act limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in cash surrender value, \$100,000 in disability insurance benefits, \$100,000 in present value of annuities, or \$100,000 in life insurance death benefits--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of



coverages. There is a \$1,000,000 limit with respect to any one contractholder for unallocated annuity benefits irrespective of the number of contracts held by the contractholder.

#### **Exclusions from Coverage**

However, persons holding policies, certificates, or contracts are not protected by the Association if:

1. they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
2. the insurer was not authorized to do business in this state;
3. the insurer or other entity is not required by the Act to be a member of the Association.

The Association also does not provide coverage for:

1. any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2. any policy of reinsurance (unless an assumption certificate was issued);
3. interest rate yields that do not meet certain specifications described in the Act;
4. dividends or experience rating credits;
5. Association and employee benefit plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
6. certain other plans and benefits which are excluded under the Act.

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## **SPECIFICATIONS**

This section contains many of the features of your short term disability (STD) insurance. Other provisions, including exclusions, limitations, and Other Income, appear in other sections. Please refer to the text of each section for full details. The Guide To Policy Provisions and Index Of Defined Terms help locate sections and definitions.

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### **GENERAL INFORMATION**

<b>Policy Number:</b>	SAMPLE
<b>Policyowner:</b>	ABC Company
<b>Employer:</b>	ABC Company XYZ Affiliate
<b>Policy Effective Date:</b>	January 1, 1992
<b>Policy Issued In:</b>	Arkansas

---

### **SECTION 1. BECOMING INSURED**

**To become insured you must:**

- \* Be a Member;
- \* Complete your Eligibility Waiting Period For Insurance; and
- \* Meet the other requirements in Section 1. Becoming Insured.

**Definition of Member:**  
[variable; Employer determined]

- \* An active employee of the Employer;
- \* A citizen or resident of the United States or Canada; and
- \* Regularly working 30 or more hours per week for the Employer;

You are not a Member if you are:

- \* A temporary or seasonal employee; or
- \* A full time member of the armed forces of any country.

**Eligibility Waiting  
Period For Insurance:**  
[variable; Employer determined]

This is the period you must be a Member before you become eligible for insurance.

You meet the Eligibility Waiting Period For Insurance on the later of the Policy Effective Date; and the first day after 365 consecutive days as a Member.

**Evidence Of Insurability:**

Required for:

[Optional, for Contributory only:

- \* Late application for Contributory insurance;]
- \* Reinstatements if required; and
- \* Members eligible but not insured under the Prior Plan.

**Member Contributions:**  
[variable;

Noncontributory. The Policyowner or Employer pays the entire premium for your insurance.

-Or-

Contributory. You pay all or part of the premium for your insurance.

---

## **SECTION 2. BENEFITS**

### **2.3 BENEFIT TERMS**

**Beginning Date:**

[variable; e.g. 31st] day of each period of Disability caused by accidental Injury.

[variable; e.g. 31st] day of each period of Disability caused by Sickness or Pregnancy.

**Maximum Benefit**

[variable; ranges from 40% to 75%] of your Predisability Earnings not to exceed:

- \* [variable; ranges from \$50 to \$3,500] if Preexisting Condition

Limitation applies; or

\* [variable; ranges from \$50 to \$5,000] if Preexisting Condition  
Limitation does not apply.

**Minimum Benefit:** [variable; ranges from \$0 to \$25].

**Maximum Benefit Period** [variable; ranges from 15 days to 104 weeks]

**Predisability Earnings:** Based on last full day of Active Work.

**Earnings Period:** The preceding [variable; e.g. 52, 104, or 156] weeks.

## **2.4 DEFINITION OF DISABILITY**

[Optional:  
**Partial Disability:** Covered.

**Partial Disability  
Income Percentage:** [variable; ranges from 40% to 80%]  
of your Predisability Earnings.]

## **2.5 BENEFIT AMOUNTS**

**STD Benefit:** Your Maximum Benefit minus your  
Other Income.

[Optional:  
**Return To Work  
50% Offset Benefit:** Your STD Benefit minus one-half  
your Work Earnings.]

---

## **SECTION 4. EXCLUSIONS AND LIMITATIONS**

**4.1 EXCLUSION:** [Optional Exclusion:  
\* Work Related;]  
\* Intentionally self-inflicted  
injury; and  
\* War.

**4.2 LIMITATIONS** \* Physician Or Practitioner;  
[Optional Limitation:  
\* Occupational Benefits;]  
[Optional Limitation:  
\* Paid Sick Leave;]  
[Optional Limitation:  
\* Working; and]

[Optional Limitation:  
\* Preexisting Condition]

[Optional:  
Preexisting Condition  
Period:

The [variable; ranges from 30 to  
365]-day period just before the  
date your insurance becomes  
effective.

Limitation Period:

The first [variable; 12, 24] months  
you are insured.]

---

## SECTION 5. TERMINATION

### 5.1 WHEN INSURANCE ENDS

Leave of Absence Period: Insurance is continued while on a  
leave of absence scheduled to last  
[30] days or less.

---

## SECTION 8. PREMIUMS

Premium Rate during Initial  
Rate Guarantee Period:

[0.13%] per \$1.00 of each insured  
Member's Maximum Benefit.

### 8.2 CHANGES

Initial Rate  
Guarantee Period:

[variable; ranges from 6 months to  
2 years].

Advance Notice Period:

31 days.

### 8.3 PAYMENT OF PREMIUMS

Premium Due Dates:

[January 1, 1992] and the first day  
of each calendar month thereafter.

### 8.4 GRACE PERIOD

Grace Period:

31 days.



## **SECTION 9. THE CONTRACT**

### **9.7 TERMINATION OF CONTRACT**

#### **Minimum Participation:**

Number: 10 Members.  
Percentage: [variable;  
100% of Members if Noncontributory.

- Or -

75% of Members if Contributory.

**Advance Notice Period:** 31 days.

## **SECTION 1. BECOMING INSURED**

[variable language]

- if insurance is Noncontributory -

### **1.1 INITIAL EFFECTIVE DATE**

You are eligible for insurance if you are a Member who has completed the Eligibility Waiting Period For Insurance shown in the Specifications. Subject to the Active Work Requirement, your Noncontributory insurance will become effective as determined in this section.

**Evidence Of Insurability Not Required.** Insurance not subject to Evidence Of Insurability will become effective on the date you meet the Eligibility Waiting Period For Insurance.

**Evidence Of Insurability Required.** Insurance subject to Evidence Of Insurability will become effective on the date the Company approves your Evidence Of Insurability.

**Evidence Of Insurability.** When required you must:

- \* Complete the forms required by the Company;
- \* Sign the forms which allow the Company to obtain information about you;
- \* Provide, at your expense, other information the Company may reasonably require for determining your insurability; and
- \* Undergo a physical examination, if required by the Company [Optional language: ", which may include blood testing"].

- if insurance is Contributory -

### **1.1 INITIAL EFFECTIVE DATE**

You are eligible for insurance if you are a Member who has completed the Eligibility Waiting Period For Insurance shown in the Specifications. To become insured for Contributory insurance you must apply in writing and agree to pay premiums. Subject to the Active Work Requirement, your Contributory insurance will become effective as determined in this section.

**Evidence Of Insurability Not Required.** Insurance not subject to Evidence Of Insurability will become effective on:

- \* The date you meet the Eligibility Waiting Period For Insurance, if you apply on or before that date; or

- \* The date you apply, if you apply within 31 days after the date you meet the Eligibility Waiting Period For Insurance.

**Late Application.** Evidence Of Insurability is required if you apply for Contributory insurance more than 31 days after the date you meet the Eligibility Waiting Period For Insurance.

**Evidence Of Insurability Required.** Insurance subject to Evidence Of Insurability will become effective on the date the Company approves your Evidence Of Insurability.

**Evidence Of Insurability.** When required you must:

- \* Complete the forms required by the Company;
- \* Sign the forms which allow the Company to obtain information about you;
- \* Provide, at your expense, other information the Company may reasonably require for determining your insurability; and
- \* Undergo a physical examination, if required by the Company [Optional language: ", which may include blood testing"].

## **1.2 DELAYED EFFECTIVE DATE**

If you do not meet the Active Work Requirement, the effective date of your insurance is delayed. Delayed insurance becomes effective on the day after you complete one full day of Active Work.

## **1.3 ACTIVE WORK REQUIREMENT**

The Active Work Requirement is met if you are a Member who is Actively At Work on the day before the scheduled effective date of your insurance. It is also met if you:

- \* Are capable of Active Work on that day, but are absent due to vacation, holiday, or scheduled day off; and
- \* Were Actively At Work on the last scheduled work day before the absence.

**Actively At Work and Active Work.** This means you are performing the material duties of your Own Occupation at your Employer's usual place(s) of business.

#### **1.4 REPLACEMENT COVERAGE**

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Policy, you do not have to meet the Eligibility Waiting Period For Insurance shown in the Specifications. [Optional, included if insurance is Contributory: If you were eligible for insurance under the Prior Plan for more than 31 days but were not insured, you must provide satisfactory Evidence Of Insurability to become insured under the Policy.]

**Prior Plan.** This means your Employer's group short term disability insurance plan in effect on the day before the effective date of your Employer's coverage under the Policy and which is replaced by the Policy.

#### **1.5 INCREASED INSURANCE**

An increase in your insurance does not become effective until you meet the Active Work Requirement. However, if you meet the Active Work Requirement while Disabled or during a period of Temporary Recovery, you will not qualify for any increase in insurance.

#### **1.6 INCONTESTABILITY**

When Evidence Of Insurability is required, the Company relies on the information provided. Any statement you make to obtain insurance is a representation and not a warranty. The Company may contest the validity of your insurance or reduce or deny a claim if:

- \* The information you provide contains a misrepresentation;
- \* Your insurance would not have been approved if the Company had known the truth; and
- \* The Company has given you a copy of the written instrument signed by you which contains the misrepresentation.

After your insurance has been in effect for two years, the Company will not use a misrepresentation to contest its validity or reduce or deny your claim for a Disability that begins after the two year period, unless the misrepresentation was fraudulent.

## **SECTION 2. BENEFITS**

### **2.1 INSURING CLAUSE**

Benefits become payable for your Disability only if:

- \* You become Disabled while insured under the Policy;
- \* You are under the ongoing care of a Physician Or Practitioner;
- \* Your Disability results from an Injury, Sickness, or Pregnancy;
- \* You give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date;
- \* Your Disability is not excluded under Section 4. Exclusions And Limitations; and
- \* You meet all other terms of the Policy.

### **2.2 BENEFIT TERMS**

**Beginning Date.** This is the date on which benefits begin to accrue after you become Disabled. Benefits are not payable for the time you are Disabled before the Beginning Date. See Specifications.

**Maximum Benefit.** Your Maximum Benefit is shown in the Specifications.

**Minimum Benefit.** Your Minimum Benefit is shown in the Specifications.

**Maximum Benefit Period.** This is the longest period for which benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins on the Beginning Date. No STD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See Specifications

[variable; e.g.

**Predisability Earnings.** Your Predisability Earnings for each uninterrupted period of Disability will be the Predisability Earnings in effect on the date shown in the Specifications. Any change in your earnings after that date will not affect your Predisability Earnings.

**Sole Proprietors, Partners, and S-Corporation Shareholders.** Predisability Earnings means your average weekly compensation from your Employer during the Employer's prior tax year. Your

average weekly compensation is determined by adding the following amounts as reported on Schedule C, Schedule K-1, Form W-2, or S-Corporation federal income tax return, and dividing by 52:

- \* Your net profit from business;
- \* Your ordinary income from trade or business activity(ies);
- \* Your guaranteed payments, if you are a partner; and
- \* Your compensation (as an officer), salary, and wages, if you are an S-corporation shareholder.

If you were not a sole proprietor, partner, or shareholder of the Employer during the entire prior tax year, your Predisability Earnings will be your average weekly compensation for your period as a sole proprietor, partner, or shareholder.

**All Other Members.** Predisability Earnings means your weekly rate of earnings from your Employer, including:

- \* Commissions averaged over the Earnings Period shown in the Specifications or over the period of your employment if less than the Earnings Period; and
- \* Shift differential pay.

Predisability Earnings does not include:

- \* Bonuses;
- \* Overtime pay; and
- \* Any other extra compensation.

If you are paid on an annual contract basis, your weekly rate of earnings is based on one-fifty second (1/52nd) of your annual contract salary.

If you are paid hourly, your weekly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week, but not more than 40 hours. If you do not have regular work hours, your weekly rate of earnings is based on the average number of hours you worked per week during the preceding 52 weeks (or during your period of employment if less than 52 weeks), but not more than 40 hours.

**All Members.** Predisability Earnings includes contributions you make through a salary reduction agreement with your Employer to:

- \* An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), or 457 deferred compensation arrangement;
- \* An executive, nonqualified deferred compensation arrangement; or
- \* An IRC Section 125 plan.

Predisability Earnings does not include your Employer's contributions on your behalf to any deferred compensation arrangement, pension plan, or benefit plan.]

**Injury.** This is an injury to your body.

**Physician Or Practitioner.** This is a licensed medical professional, other than yourself, diagnosing and treating you within the scope of the license.

**Pregnancy.** This is your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

**Sickness.** This is your sickness, illness, or disease.

## 2.3 DEFINITION OF DISABILITY

[variable language]

- if Partial Disability is not covered -

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation.

- if Partial Disability is covered -

You are Disabled if you meet either of the following definitions:

- \* Definition of Disability; or
- \* Definition of Partial Disability.

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation.

**Definition Of Partial Disability.** You are Partially Disabled if you are working for your Employer but, as a result of Sickness, Injury, or Pregnancy, are unable to earn more than the Partial Disability Income Percentage shown in the Specifications.

## **2.4 WORKING WHILE DISABLED**

You may accrue days toward the Beginning Date while working if you are Disabled.

During the Maximum Benefit Period, benefits are payable while you are working if you are Disabled. However, one-half of your Work Earnings will be used to reduce your benefit as shown in 2.5 Benefit Amounts.

## **2.5 BENEFIT AMOUNTS**

[Optional:

The benefit payable during your Disability will be one of the benefits described in this section, subject to the Maximum Benefit and Minimum Benefit shown in the Specifications.]

**STD Benefit.** This is your Maximum Benefit minus your Other Income. Your Maximum Benefit is shown in the Specifications.

[Optional:

**Return To Work 50% Offset Benefit.** This is your STD Benefit minus one-half of your Work Earnings.

**Work Earnings.** This is your gross weekly earnings from work you perform for your Employer while Disabled. Your earnings will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than weekly, the Company will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, the Company will use a reasonable one.]

[Optional:

**Daily Hospital Benefit.** The Company will pay you a Daily Hospital Benefit equal to one-seventh of your benefit for each day prior to your Beginning Date that you are confined in a Hospital for at least four hours.

The Daily Hospital Benefit will not be paid for days you are confined to a Hospital after your Beginning Date.

- Or -

**First Day Hospital Benefit.** If you are confined in a Hospital for at least four hours prior to your Beginning Date, the following will apply:

- \* The unaccrued days toward your Beginning Date will be waived;
- \* Benefits will become payable on the first day of Hospital confinement;



\* Your Maximum Benefit Period will begin on the date benefits become payable; and

\* You must be under the ongoing care of a Physician Or Practitioner during your Hospital confinement.]

[Optional:

Hospital. This is a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.]

When a Disability lasts for a part of a week, 1/7th of the full benefit will be payable for each day you are Disabled.

[Optional:

#### **2.6 WAIVER OF PREMIUM**

The Company will waive premiums for your insurance while benefits are payable to you.]

#### **2.7 ASSIGNMENT**

The rights and benefits under the Policy are not assignable.

#### **2.8 CONTINUATION OF BENEFITS**

Your right to receive benefits for a period of Disability which begins while you are insured will not be affected by:

- \* Termination of the Policy after you become Disabled;
- \* Termination of your insurance while the Policy remains in force; or
- \* Any amendment to the Policy approved after the date you become Disabled.

#### **2.9 WHEN BENEFITS END**

Your benefits end automatically on the earliest of:

- \* The date you are no longer Disabled;
- \* The date your Maximum Benefit Period ends;
- \* The date you die; and

[Optional; included if LTD policy is also in force:

- \* The date long term disability benefits become payable to you under a group LTD insurance policy issued by the Company.]

### SECTION 3. BENEFIT PROVISIONS

#### 3.1 OTHER INCOME

Other Income. The amounts below are Other Income:

[Optional:

- \* The amount of your sick pay or other salary continuation (but not vacation pay) [variable; paid, payable] to you by your Employer;

- Or -

- \* The amount of your sick pay or other salary continuation (but not vacation pay) [variable; paid, payable] to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;]

[Optional:

- \* Any amount you receive or are eligible to receive as a result of your disability from any state disability income benefit law or similar law;]

[Optional:

- \* Any amount you, your spouse or your children receive or are eligible to receive as a result of your disability or retirement under the Federal Social Security Act. Early retirement benefits payable prior to normal retirement age under the act will not be used to reduce the amount of your benefit unless they are actually received;]

[Optional, added when insurance is 24-hour coverage:

- \* Any amount you receive or are eligible to receive as a result of your disability under a Worker's Compensation Act or similar law, including amounts for partial or total disability, whether permanent or temporary;] and

[Optional:

- \* Any amount you receive or are eligible to receive due to compromise, settlement, or other method as a result of a claim for any Other Income, whether disputed or undisputed.]

### **3.2 RULES FOR OTHER INCOME**

**Weekly Equivalents.** Each week the Company will determine your benefit using the Other Income attributable to the same weekly period, even if you actually receive the Other Income in another week.

If you are paid Other Income in a lump sum or by a method other than weekly, the Company will determine your benefit using a prorated amount. The Company will use the period of time to which the Other Income applies. If no period of time is stated, the Company will use a reasonable one.

**Your Duty To Pursue Other Income.** You must pursue Other Income for which you may be eligible. The Company may ask for written documentation of your pursuit of Other Income. You must provide satisfactory documentation within 60 days after the Company mails you a request. Otherwise, the Company may reduce your benefits by the amount the Company estimates you would be eligible to receive upon proper pursuit of the Other Income. You must notify the Company of the amount of the Other Income when it is approved.

**Overpayment Of Claim.** You must immediately repay the Company any overpayment of your claim. The Company will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by the Company. You will not receive any benefits until the Company has been repaid in full. In the meantime, any benefits paid, including the Minimum Benefit, will be applied to reduce the amount of the overpayment. The Company may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after the Company first mails you notice of the amount of the overpayment.

### **3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES**

You may temporarily recover from your Disability, and then become Disabled again from the same cause or causes, without having to start accruing days toward a new Beginning Date.

**Temporary Recovery.** This means you cease to be Disabled for no more than the following allowable period:

**Allowable Period.** The allowable period of recovery during the Maximum Benefit Period is 14 days.

**Effect Of Your Temporary Recovery:**

- \* The Predisability Earnings used to determine your benefit will not change;

- \* The period of Temporary Recovery will not count toward your Maximum Benefit Period;
- \* No benefits will be payable for the period of Temporary Recovery; and
- \* Except as stated above, the provisions of the Policy will be applied as if there had been no interruption of your Disability.

**Separate Disabilities.** Each time you cease to be Disabled for more than the allowable period, a new Maximum Benefit Period applies.

### **3.4 EXTENDED DISABILITY**

If a period of Disability is extended by a new cause while benefits are payable, benefits will continue while you remain Disabled. However:

- \* Benefits will not continue beyond the end of the original Maximum Benefit Period; and
- \* Section 4. Exclusions And Limitations will apply to the new cause of Disability.

### **3.5 MISSTATEMENT OF AGE**

If a person's age has been misstated, the Company will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

- \* The amount of insurance based on the correct age; and
- \* The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

## **SECTION 4. EXCLUSIONS AND LIMITATIONS**

### **4.1 EXCLUSIONS**

You are not covered for a Disability:

[Optional, applies to non-occupational coverage:

- \* Arising out of or in the course of any employment for wage or profit;]
- \* Caused or contributed to by an intentionally self-inflicted injury, while sane or insane; or

\* Caused or contributed to by War or any act of War.

War. This is declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

#### 4.2 LIMITATIONS

**Physician Or Practitioner.** You must be under the ongoing care of a Physician Or Practitioner during your Disability. No benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician Or Practitioner.

[Optional, applies to non-occupational coverage:

**Occupational Benefits.** No benefits will be paid for any period when you are eligible to receive benefits under a workers' compensation law or similar law. If your claim for these benefits is accepted, compromised, or settled (whether disputed or undisputed), you must repay the Company for the full amount of any payments the Company makes to you while your claim for occupational benefits is pending.]

[Optional:

**Paid Sick Leave.** No benefits will be paid for any period when you are receiving paid sick leave from your Employer.]

[Optional:

**Working.** No benefits will be paid for any period when:

- \* You are working for wage or profit for any employer other than your Employer; or
- \* You are self-employed.]

[Optional:

**Preexisting Condition.** Your benefit will be limited as shown in the Specifications if your Disability is caused or contributed to by a Preexisting Condition. However, this limitation will not apply if you meet both of the following on the date you become Disabled:

- \* You have been continuously insured under the Policy for the entire Limitation Period shown in the Specifications; and
- \* You have been Actively At Work for at least one full day after the end of the Limitation Period.

**Preexisting Condition.** This is a mental or physical condition for which you have consulted a Physician Or Practitioner, received medical treatment or services, or taken prescribed drugs or medications at any time during the Preexisting Condition

Period shown in the .Specifications.]

#### 4.3 CONTINUITY OF COVERAGE

The Continuity of Coverage provision changes other provisions found in the Policy.

**Waiver Of Active Work Requirement.** If you were insured under the Prior Plan on the day before the effective date of your Employer's insurance under the Policy, you can become insured on the effective date of your Employer's insurance without meeting the Active Work Requirement.

The benefit payable for a period of continuous Disability beginning before you meet the Active Work Requirement will be:

- \* The weekly benefit payable under the terms of the Policy; reduced by
- \* Any benefits payable under the Prior Plan.

There is no Minimum Benefit if there is a reduction because of benefits payable under the Prior Plan.

**Waiver Of Preexisting Conditions.** If your Disability is subject to the Preexisting Condition Limitation, benefits will not be limited if:

- \* You were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Policy;
- \* You became insured under the Policy when your insurance under the Prior Plan ceased;
- \* You were continuously insured under the Policy from the effective date of your insurance under the Policy through the date you became Disabled from the Preexisting Condition; and
- \* Benefits would have been payable under the Prior Plan if it had remained in force, taking into account the preexisting condition limitation, if any, of the Prior Plan.

Payment of your benefit will be made under the terms of the Policy.

## **SECTION 5. TERMINATION**

### **5.1 WHEN INSURANCE ENDS**

Your insurance ends automatically on the earliest of:

[Optional, included when insurance is Contributory:

- \* The date the last period ends for which you made a premium contribution;]

- \* The date the Policy terminates;

- \* The date your employment terminates; and

- \* The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued during the following periods, unless it ends on one of the dates shown above:

- (1) While you are receiving from your Employer at least the amount of Predisability Earnings in effect immediately before you ceased to be a Member;

- (2) While you are Disabled before the Beginning Date and while benefits are payable; or

- (3) During a leave of absence if continuation of your insurance under the Policy is required by the state-mandated family or medical leave act or law.

- (4) During any other leave of absence approved by your Employer in advance and in writing and scheduled to last the period shown in the Specifications.

[Optional, included for school groups:

If you cease to be a Member because of a school break or vacation, your insurance will be continued during that period.]

### **5.2 REINSTATEMENT OF INSURANCE**

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- \* If your insurance ends because you cease to be a Member, and if you become a Member again within 90 days, the Eligibility Waiting Period For Insurance will be waived;

[Optional; included when insurance is Contributory:

- \* If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again;]

- \* If your insurance ends because you are on a state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the state-mandated family or medical leave act or law; and
- \* The Preexisting Condition Limitation will be applied as if there had been no break in your insurance in the following instances:
  - (1) If you become insured again within 90 days.
  - (2) If required by a state-mandated family or medical leave act or law and you become insured again immediately following the period allowed under the family or medical leave act or law.

## **SECTION 6. CLAIMS**

### **6.1 FILING A CLAIM**

Claims should be filed on the Company's forms. If you do not receive the Company's forms within 15 days after you ask for them, you may submit your claim in a letter to the Company. The letter should include the date your disability began, and the cause and nature of your disability.

### **6.2 PROOF OF LOSS**

You must give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date. If you cannot do so, you must give it to the Company as soon as reasonably possible, but not later than one year after that 90 day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

**Proof Of Loss.** This means written proof that you are Disabled and entitled to benefits. Proof Of Loss must be provided at your expense.

### **6.3 DOCUMENTATION**

At your expense, you must submit completed claims statements, your signed authorization for the Company to obtain information, and any other items the Company may reasonably require in support of your claim. If you do not provide the documentation within 60 days after the Company mails you a request, your claim may be denied.



#### **6.4 TIME OF PAYMENT**

The Company will pay benefits within 60 days after you provide satisfactory Proof Of Loss. Benefits will be paid at the end of each week you qualify for them.

#### **6.5 PAYMENT OF CLAIM**

Benefits will be paid to you. Benefits remaining unpaid at your death will be paid to your estate.

#### **6.6 INVESTIGATION OF CLAIM**

The Company may investigate your claim at any time. At its own expense, the Company may have you and your financial records examined as often as is reasonably necessary. This will be done by specialists of the Company's choice. The Company may deny or suspend benefits if you fail to attend an examination or cooperate with the examiner.

#### **6.7 NOTICE OF DECISION ON CLAIM**

You will receive a written decision on your claim within a reasonable time after the Company receives your claim.

If you do not receive the Company's decision within 90 days after the Company receives your claim, you will have an immediate right to request a review as if your claim had been denied.

If the Company denies any part of your claim, you will receive a written notice of denial containing:

- \* The reasons for the decision;
- \* Reference to the parts of the Policy on which the decision is based;
- \* A description of any additional information needed to support your claim; and
- \* Information concerning your right to a review of the decision.

#### **6.8 REVIEW PROCEDURE**

You may request in writing a review of a denial of all or part of your claim within 60 days after you receive notice of the denial.

When you request a review, you may send the Company written comments or other items to support your claim. You may review any non-privileged information that relates to your request for

review.

The Company will review your claim promptly after receiving your request. The Company will send you a notice of its decision within 60 days after receiving your request, or within 120 days if special circumstances require an extension. The Company will state the reasons for its decision and refer you to the relevant parts of the Policy.

#### **6.9 TIME LIMITS ON LEGAL ACTIONS**

No action at law or in equity may be brought until 60 days after you have given the Company Proof Of Loss. No such action may be brought more than three years after the earlier of:

- \* The date the Company receives Proof Of Loss; and
- \* The end of the period within which Proof Of Loss is required to be given.

#### **SECTION 7. ALLOCATION OF AUTHORITY**

Except for those functions which the Policy specifically reserves to the Policyowner, the Company has full and exclusive authority to control and manage the Policy, to administer claims, and to interpret the Policy and resolve all questions arising in the administration, interpretation, and application of the Policy.

The Company's authority includes, but is not limited to:

- \* The right to resolve all matters when a review has been requested;
- \* The right to establish and enforce rules and procedures for the administration of the Policy and any claim under it;
- \* The right to determine:
  - (1) Your eligibility for insurance;
  - (2) Your entitlement to benefits;
  - (3) The amount of benefits payable to you;
  - (4) The sufficiency and the amount of information the Company may reasonably require to determine 1, 2, or 3 above.

Subject to the review procedures of the Policy, any decision the Company makes in the exercise of the Company's authority is

conclusive and binding.

## **SECTION 8. PREMIUMS**

### **8.1 AMOUNTS**

The premium due on each Premium Due Date is the sum of the premiums for all Members then insured. The Policyowner determines the amount, if any, of each insured Member's contribution toward the cost of insurance.

### **8.2 CHANGES**

The Company may change Premium Rates when:

- \* A change in law or governmental regulation affects the amount payable under the Policy. Any such change in Premium Rates will reflect only the change in the Company's obligations;
- \* The number of insured Members changes by 25% or more; or
- \* The Company and the Policyowner mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in the Specifications. Thereafter, the Company may change Premium Rates upon advance written notice to the Policyowner. The minimum advance notice is shown in the Specifications as the Advance Notice Period. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

### **8.3 PAYMENT OF PREMIUM**

All premiums are due on the Premium Due Dates shown in the Specifications.

Each premium is payable on or before its Premium Due Date directly to the Company's Group Administration Office. The payment of each premium as it becomes due will maintain the Policy in force until the next Premium Due Date.

### **8.4 GRACE PERIOD**

The Grace Period shown in the Specifications will be allowed for payment of a premium that is not paid on its due date. The Policy will be in force during this period. If the premium is

not paid during the Grace Period, the Policy will terminate automatically at the end of the Grace Period. The Policyowner is liable for the payment of premium for coverage provided during the Grace Period. The Company may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

#### **8.5 PREMIUM ADJUSTMENTS**

Premium adjustments involving a return of unearned premiums to the Policyowner will be limited to the 12 months just before the date the Company receives a request for premium adjustment.

### **SECTION 9. THE CONTRACT**

#### **9.1 ENTIRE CONTRACT, CHANGES**

The Policy and the application of the Policyowner constitute the entire contract between the parties. A copy of the Policyowner's application is attached to the Policy when issued.

The Policy may be changed in whole or in part. No change in the Policy will be valid unless it is approved in writing by one of the Company's executive officers and given to the Policyowner for attachment to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

#### **9.2 INCONTESTABILITY OF POLICY**

Any statement made by the Policyowner to obtain the Policy is a representation and not a warranty.

No misrepresentation by the Policyowner will be used to deny a claim or to deny the validity of the Policy unless:

- \* The Policy would not have been issued if the Company had known the truth; and
- \* The Company has given the Policyowner a copy of a written instrument signed by the Policyowner which contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

#### **9.3 DIVIDENDS**

While the Policy is in force, it will be credited with its share, if any, of the divisible surplus in the form of dividends which the Company may declare.

If required by state law, the Policyowner will use, for the sole benefit of the insured Members, the amount of such dividends or rate reductions which exceeds the Policyowner's expenditure for insurance under the Policy.

#### **9.4 CERTIFICATES**

The Company will issue certificates to the Policyowner showing the coverage under the Policy. The Policyowner will distribute a certificate to each insured Member.

#### **9.5 RECORDS AND REPORTS**

The Policyowner or Employer will furnish on the Company's forms all information reasonably necessary to administer the Policy. The Company has the right at all reasonable times to inspect the payroll and other records of the Policyowner or Employer which relate to insurance under the Policy.

Clerical error by the Policyowner or Employer will not:

- \* Cause a person to become insured;
- \* Invalidate insurance otherwise validly in force; or
- \* Continue insurance otherwise validly terminated.

#### **9.6 EFFECT ON WORKERS' COMPENSATION, STATE DISABILITY INSURANCE**

The coverage provided under the Policy is not a substitute for coverage under a workers' compensation or state disability income benefit law. The Policy does not relieve the Employer of any obligation to provide such coverage.

#### **9.7 TERMINATION OF CONTRACT**

The Policyowner may terminate the Policy by giving the Company advance written notice. The effective date of termination will be the later of:

- \* The date stated in the notice; and
- \* The date the Company receives the notice.

The Company may terminate the Policy upon advance written notice as follows:

- \* On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number or less than the Minimum Participation Percentage shown in the Specifications.

- \* On any Premium Due Date if the Company determines that the Policyowner has failed to promptly furnish any necessary information requested by the Company, or has failed to perform any other obligations relating to the Policy.

The minimum advance notice is shown in the Specifications as the Advance Notice Period.

## **AMENDMENT TO GROUP SHORT TERM DISABILITY INSURANCE POLICY FORM**

Attached to and made a part of Group Policy Form NM 992-STD

In order to comply with the U.S. Department of Labor Regulations 29CFR 2560.503-1, **Section 6 Claims** of the Group Policy is amended as follows. The use of brackets ( [ ] ) indicate the language is optional, braces ( < > ) indicate the language is variable:

1. Item **6.3**, Documentation is amended to read as follows:

### **6.3 Documentation**

At your expense, you must submit completed claims statements, your signed authorization for the Company to obtain information, and any other items the Company may reasonably require in support of your claim. If you do not provide the documentation within <45> days after the Company mails you a request, [your/the] claim may be denied.

2. Item **6.7** Notice Of Decision On Claim is amended to read as follows:

### **6.7 Notice Of Decision On Claim**

The Company will evaluate your claim promptly after you file it. Within <45> days after the Company receives your claim the Company will send you: (a) a written decision on your claim; or (b) a notice that the Company is extending the period to decide your claim for <30> days. Before the end of this extension period the Company will send you: (a) a written decision on your claim; or (b) a notice that the Company is extending the period to decide your claim for an additional <30> days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If the Company extends the period to decide your claim, the Company will notify you of the following: (a) the reasons for the extension; (b) when the Company expects to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information the Company needs to resolve those issues.

If the Company requests additional information, you will have <45> days to provide the information. If you do not provide the requested information within <45> days, the Company may decide your claim based on the information the Company has received.

If the Company denies any part of your claim, you will receive a written notice of denial containing:

- The reasons for the decision.
- [Reference to the parts of the Policy on which the decision is based.]
- Reference to any internal rule or guideline relied upon in making the decision.

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- A description of any additional information needed to support your claim.
- Information concerning your right to a review of the decision.
- [Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.]

3. Item **6.8** Review Procedure is amended to read as follows:

**6.8 Review Procedure**

If all or part of a claim is denied, you may request a review. You must request a review in writing within <180> days after you receive notice of the denial.

You may send the Company written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to the Company about your claim.

[The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. [If the denial was based on a medical judgement, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgement and will not be subordinate to that person.] ] The Company's review will include any written comments or other items you submit to support your claim.

The Company will review your claim promptly after the Company receives your request. Within <45> days after the Company receives your request for review the Company will send you: (a) a written decision on review; or (b) a notice that the Company is extending the review period for <45> days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

If the Company extends the review period, the Company will notify you of the following: (a) the reasons for the extension; (b) when the Company expects to decide your claim on review; and (c) any additional information the Company needs to decide your claim.

If the Company requests additional information, you will have <45> days to provide the information. If you do not provide the requested information within <45> days, the Company may conclude the review of your claim based on the information the Company has received.

If the Company denies any part of your claim on review, you will receive a written notice of denial containing:

- The reasons for the decision.
- Reference to the parts of the Policy on which the decision is based.
- [Reference to any internal rule or guideline relied upon in making the decision.]

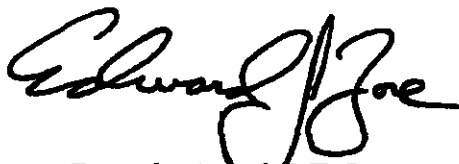


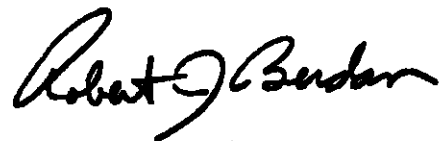
- Information concerning your right to receive free of charge copies of non-privileged documents and records relevant to your claim.
- [Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.]

[The Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and you State insurance regulatory agency for assistance.]

The Northwestern Mutual Life Insurance Company

By

  
President and C.E.O.

  
Secretary

## SHORT TERM DISABILITY INSURANCE OPTIONAL PROVISION RIDER

Attached to and made a part of Group Policy Form MN 992-STD

Group Policy Form MN 992-STD is amended to provide an update to policy language and to provide the following provisions for any Policyowner who negotiates the inclusion of such provisions into its Short Term Disability policy issued by us. For your ease in reviewing, we have *italicized the amended portions* and shown the surrounding text.

1. SECTION 4.2 LIMITATIONS of the Specifications is amended to read as follows:

**APPROVED**

**4.2 LIMITATIONS:**

- \* *Care Of A Physician Or Practitioner;*  
[Optional Limitation:  
\* Occupational Benefits;]  
[Optional Limitation:  
\* Paid Sick Leave;]  
[Optional Limitation:  
\* Working;] and  
[Optional Limitation:  
\* Preexisting Condition.]

**JAN 15 1997**

INSURANCE COMMISSIONER  
STATE OF ARKANSAS

2. The definition of **Actively At Work** and **Active Work** in SECTION 1.3 **ACTIVE WORK REQUIREMENT** is amended to read as follows:

**Actively At Work and Active Work.** This means you are performing the *Material Duties* of your Own Occupation at your Employer's usual place(s) of business.

3. The following terms in SECTION 2.2 **BENEFIT TERMS** are amended to read as follows:

**Mental Disorder.** *This is any disease, condition or disorder whether organic or inorganic, customarily within the scope of treatment of psychiatrists, psychologists, psychotherapists or counselors. This includes, but is not limited to:*

- \* *psychosis, psychoneurosis, anxiety and depression; and*
- \* *behavioral, adjustment, emotional, personality and stress-related disorders.*

**Physician Or Practitioner.** This is a licensed medical professional, other than yourself, acting within the scope of the license. *If Disability is primarily due to any Mental Disorder, Physician or Practitioner means a psychiatrist or licensed doctoral level psychologist, other than yourself.*

4. SECTION 2.3 **DEFINITION OF DISABILITY** is amended to read as follows:

*[Optional language to be used with or without inclusion of Partial Disability:*

*Own Occupation. This is any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as your regular and ordinary employment with your Employer. Your Own Occupation is not limited to your specific job with your Employer or to your specific area of specialization, interest or expertise within the general occupation.]*

[Optional:

**Material Duties.** *These are the essential tasks, functions and operation, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation.]*

[Variable language] - if Partial Disability is not covered -

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the *Material Duties* of your *Own Occupation*.

- if Partial Disability is covered -

You are Disabled if you meet either of the following definitions:

- \* Definition of Disability; or
- \* Definition of Partial Disability.

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the *Material Duties* of your *Own Occupation*.]

**Definition Of Partial Disability.** You are Partially Disabled if you are working for your Employer but, as a result of Sickness, Injury, or Pregnancy, are unable to earn more than the Partial Disability Income Percentage shown in the *Specifications*.

5. The definition of Hospital in SECTION 2.5 BENEFIT AMOUNTS is amended to read as follows:

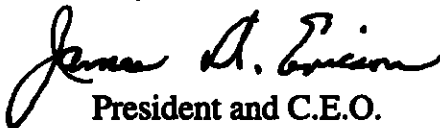
**Hospital.** This is a legally operated *facility identified as a hospital and* providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. "*Hospital*" does not include rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care.

6. The following term in SECTION 4.2 LIMITATIONS is amended to read as follows:

**Care Of A Physician Or Practitioner.** You must be under the ongoing care of a Physician Or Practitioner. No benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician Or Practitioner.

The Northwestern Mutual Life Insurance Company

By

  
President and C.E.O.

  
Secretary

**APPROVED**

**JUL 30 1993**

Insurance Commissioner  
State of Arkansas

immediately following the period allowed under the family or medical leave act or law.

**SECTION 6. CLAIMS**

**COMPLIANCE**

**AUG 03 1993**

**6.1 FILING A CLAIM**

Claims should be filed on the Company's forms. If you do not receive the Company's forms within 15 days after you ask for them, you may submit your claim in a letter to the Company. The letter should include the date your disability began, and the cause and nature of your disability.

**6.2 PROOF OF LOSS**

You must give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date. If you cannot do so, you must give it to the Company as soon as reasonably possible, but not later than one year after that 90 day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

**Proof Of Loss.** This means written proof that you are Disabled and entitled to benefits. Proof Of Loss must be provided at your expense.

**6.3 DOCUMENTATION**

At your expense, you must submit completed claims statements, your signed authorization for the Company to obtain information, and any other items the Company may reasonably require in support of your claim. If you do not provide the documentation within 60 days after the Company mails you a request, your claim may be denied.

**6.4 TIME OF PAYMENT**

The Company will pay benefits within 30 days after you provide satisfactory Proof Of Loss. Benefits will be paid at the end of each week you qualify for them.

**6.5 PAYMENT OF CLAIM**

Benefits will be paid to you. Benefits remaining unpaid at your death will be paid to your estate.

**6.6 INVESTIGATION OF CLAIM**

The Company may investigate your claim at any time. At its own expense, the Company may have you and your financial records examined as often as is reasonably necessary. This will be done

**DISAPPROVED**  
**DEC 08 1992**  
**INSURANCE COMMISSIONER**  
**STATE OF ARKANSAS**

review.

The Company will review your claim promptly after receiving your request. The Company will send you a notice of its decision within 60 days after receiving your request, or within 120 days if special circumstances require an extension. The Company will state the reasons for its decision and refer you to the relevant parts of the Policy.

#### 6.9 TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given the Company Proof Of Loss. No such action may be brought more than three years after the earlier of:

- \* The date the Company receives Proof Of Loss; and
- \* The end of the period within which Proof Of Loss is required to be given.

#### SECTION 7. ALLOCATION OF AUTHORITY

Except for those functions which the Policy specifically reserves to the Policyowner, the Company has full and exclusive authority to control and manage the Policy, to administer claims, and to interpret the Policy and resolve all questions arising in the administration, interpretation, and application of the Policy.

The Company's authority includes, but is not limited to:

- \* The right to resolve all matters when a review has been requested;
- \* The right to establish and enforce rules and procedures for the administration of the Policy and any claim under it;
- \* The right to determine:
  - (1) Your eligibility for insurance;
  - (2) Your entitlement to benefits;
  - (3) The amount of benefits payable to you;
  - (4) The sufficiency and the amount of information the Company may reasonably require to determine 1, 2, or 3 above.

**APPROVED**

**JUL 30 1993**

**Insurance Commissioner  
State of Arkansas**

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**APPROVED**  
**JUL 30 1993**

*Insurance Commissioner  
State of Arkansas*

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**LIMITATIONS AND EXCLUSIONS UNDER THE  
ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in this state. You should not rely on coverage by the Arkansas Life and Health Insurance Guaranty Association in selecting an insurance company or in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to give or send you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201**

**Arkansas Insurance Department  
1200 West Third St  
Little Rock, Arkansas 72201-1904**

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding policies are **NOT** protected by the Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

The Association also does **NOT** provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).

## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Guaranty Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contractholder for unallocated annuity benefits irrespective of the number of contracts held by the contractholder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.



STATE OF ARKANSAS  
REQUIRED POLICY INFORMATION

Insurance Department  
Address

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201

Telephone Number

(501) 371-2640 or (800) 852-5494

Name and Address of  
the Insurance Company

The Northwestern Mutual Life Insurance  
Company  
Group Insurance Administration  
P.O. Box 2177  
Portland, OR 97208-2177

Telephone Number

(800) 378-4665

Name, Address, and  
Telephone Number  
of the Agent

Agent Name  
Street Address  
City, State, Zipcode  
Telephone Number

## GROUP INSURANCE POLICY

## NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 720 East Wisconsin Ave., Milwaukee WI 53202  
GROUP INSURANCE ADMINISTRATION: PO Box 2177, Portland OR 97208

<b>POLICY NUMBER</b>	S#####
<b>NAME OF POLICYOWNER</b>	Name
<b>TYPE OF COVERAGE</b>	Group Short Term Disability
<b>POLICY EFFECTIVE DATE</b>	mm/dd/yyyy

The Northwestern Mutual Life Insurance Company agrees to pay the benefits provided by the Policy, in accordance with the provisions of the Policy.

The consideration for the Policy is the application of the Policyowner and the payment by the Policyowner of premiums as provided herein.

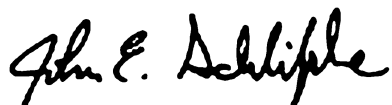
The Policy is issued for the Initial Rate Guarantee Period shown in the **Specifications**. The Policy may be renewed for successive renewal periods by the payment of the Premium on each renewal date, provided the number of persons insured on each renewal date is neither less than the Minimum Participation Number nor less than the Minimum Participation Percentage shown in the **Specifications**. The length of successive renewal periods will be determined by the Company, but will not be less than 12 months.

For purposes of effective dates and ending dates under the Policy, all days begin and end at 12:01 A.M. Standard Time at the Policyowner's address.

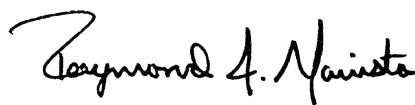
All provisions on this and the following pages are part of the Policy. The terms "you" and "your" refer to the insured Member. The term "the Company" refers to Northwestern Mutual Life. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear capitalized and in boldface type.

The Northwestern Mutual Life Insurance Company

By



Chief Executive Officer



Secretary

**LIMITATIONS AND EXCLUSIONS UNDER THE  
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Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to give or send you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

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The Association also does **NOT** provide coverage for:

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- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is not insured by an insurance company, even if an insurance company administers them);
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## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Guaranty Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contractholder for unallocated annuity benefits irrespective of the number of contracts held by the contractholder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

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Telephone Number

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Name, Address, and  
Telephone Number  
of the Agent

Agent Name  
Street Address  
City, State, Zipcode  
Telephone Number

## Guide To Policy Provisions

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## SPECIFICATIONS

This section contains many of the features of your short term disability (STD) insurance. Other provisions, including exclusions, limitations, and Other Income, appear in other sections. Please refer to the text of each section for full details. The **Guide To Policy Provisions** and **Index of Defined Terms** help locate sections and definitions.

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### GENERAL INFORMATION

<b>Policy Number:</b>	S#####
<b>Policyowner:</b>	Name
<b>Employer:</b>	Name
<b>Policy Effective Date:</b>	mm/dd/yyyy
<b>Policy Issued In:</b>	Arkansas

---

### SECTION 1. BECOMING INSURED

**To become insured you must:**

- \* Be a Member;
- \* Complete your Eligibility Waiting Period For Insurance; and
- \* Meet the other requirements in **Section 1. Becoming Insured.**

**Definition of Member:**

- \* An active employee of the Employer;
- \* A citizen or resident of the United States or Canada; and
- \* Regularly working 30 or more hours per week for the Employer.

You are not a Member if you are:

- \* A temporary or seasonal employee; or
- \* A full time member of the armed forces of any country.

**Eligibility Waiting  
Period For Insurance:**

This is the period you must be a Member before you become eligible for insurance.

If you are a Member on the Policy Effective Date, you meet the Eligibility Waiting Period For Insurance on that date.

If you become a Member after the Policy Effective Date, you meet the Eligibility Waiting Period For Insurance on the first day of the calendar month coinciding with or next following 90 consecutive days as a Member.

**Evidence Of Insurability:**

Required for:

- \* Late application for Contributory insurance;
- \* Reinstatements if required; and
- \* Members eligible but not insured under the Prior Plan.

**Member Contributions:****Noncontributory.** The Policyowner or Employer pays the entire premium for your insurance.

---

**SECTION 2. BENEFITS****2.2 BENEFIT TERMS**

<b>Beginning Date:</b>	1st day of each period of Disability caused by accidental Injury.  8th day of each period of Disability caused by Sickness or Pregnancy.
<b>Maximum Benefit:</b>	60% of your Predisability Earnings, not to exceed a weekly amount of \$1,000.
<b>Minimum Benefit:</b>	\$15
<b>Maximum Benefit Period:</b>	13 weeks.
<b>Predisability Earnings:</b>	Based on your last full day of Active Work.
<b>Earnings Period for Commissions:</b>	The preceding 52 calendar weeks.

**2.3 DEFINITION OF DISABILITY**

<b>Partial Disability:</b>	Covered.
<b>Partial Disability Income Percentage:</b>	80% of your Predisability Earnings.

**2.5 BENEFIT AMOUNTS**

<b>STD Benefit:</b>	Your Maximum Benefit minus your Other Income.
<b>Return To Work 50% Offset Benefit:</b>	Your STD Benefit minus one-half your Work Earnings.

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**SECTION 4. EXCLUSIONS AND LIMITATIONS****4.1 EXCLUSIONS**

- \* Work Related;
- \* Intentionally self-inflicted injury; and
- \* War.

## 4.2 LIMITATIONS

- \* Care Of A Physician Or Practitioner;
- \* Occupational Benefits; and
- \* Working.

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## SECTION 5. TERMINATION

### 5.1 WHEN INSURANCE ENDS

**Leave of Absence  
Period:**

Insurance is continued while on a leave of absence scheduled to last 30 days or less.

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## SECTION 8. PREMIUMS

**Premium Rate during Initial  
Rate Guarantee Period:**

\$0.500 per \$1.00 of each insured Member's Maximum Benefit.

### 8.2 CHANGES

**Initial Rate  
Guarantee Period:**

May 1, 2012 to March 1, 2012.

**Advance Notice Period:**

60 days.

### 8.3 PAYMENT OF PREMIUMS

**Premium Due Dates:**

May 1, 2012 and the first day of each calendar month thereafter.

### 8.4 GRACE PERIOD

**Grace Period:**

31 days.

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## SECTION 9. THE CONTRACT

### 9.1 TERMINATION OF CONTRACT

**Minimum Participation:**

Number: 10 Members.

Percentage: 100% of Members.

**Advance Notice Period:**

60 days.

## SECTION 1. BECOMING INSURED

### 1.1 INITIAL EFFECTIVE DATE

You are eligible for insurance if you are a Member who has completed the Eligibility Waiting Period For Insurance shown in the **Specifications**. Subject to the Active Work Requirement, your insurance will become effective as determined in this section. Additionally, to become insured for Contributory insurance you must also apply in writing and agree to pay premiums. The **Specifications** states whether your insurance is Contributory or Noncontributory.

**Evidence Of Insurability Not Required.** Insurance not subject to Evidence Of Insurability will become effective on:

- \* The date you meet the Eligibility Waiting Period For Insurance, if insurance is Noncontributory;
- \* The date you meet the Eligibility Waiting Period For Insurance, if insurance is Contributory and you apply on or before that date; or
- \* The date you apply, if insurance is Contributory and you apply within 31 days after the date you meet the Eligibility Waiting Period For Insurance.

**Late Application.** Evidence Of Insurability is required if you apply for Contributory insurance more than 31 days after the date you meet the Eligibility Waiting Period For Insurance.

**Evidence Of Insurability Required.** Insurance subject to Evidence Of Insurability will become effective on the date the Company approves your Evidence Of Insurability.

**Evidence Of Insurability.** When required you must:

- \* Complete the forms required by the Company;
- \* Sign the forms which allow the Company to obtain information about you;
- \* Provide, at your expense, other information the Company may reasonably require for determining your insurability; and
- \* Undergo a physical examination, if required by the Company.

### 1.2 DELAYED EFFECTIVE DATE

If you do not meet the Active Work Requirement, the effective date of your insurance is delayed. Delayed insurance becomes effective on the day after you complete one full day of Active Work.

### 1.3 ACTIVE WORK REQUIREMENT

The Active Work Requirement is met if you are a Member who is Actively At Work on the day before the scheduled effective date of your insurance. It is also met if you:

- \* Are capable of Active Work on that day, but are absent due to vacation, holiday, or scheduled day off; and
- \* Were Actively At Work on the last scheduled work day before the absence.

**Actively At Work and Active Work.** This means you are performing the Material Duties of your Own Occupation at your Employer's usual place(s) of business.

#### **1.4 REPLACEMENT COVERAGE**

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Policy, you do not have to meet the Eligibility Waiting Period For Insurance shown in the **Specifications**.

If your insurance is Contributory and you were eligible for insurance under the Prior Plan for more than 31 days but were not insured, you must provide satisfactory Evidence Of Insurability to become insured under the Policy.

**Prior Plan.** This means your Employer's group short term disability insurance plan in effect on the day before the effective date of your Employer's coverage under the Policy and which is replaced by the Policy.

#### **1.5 INCREASED INSURANCE**

An increase in your insurance does not become effective until you meet the Active Work Requirement. However, if you meet the Active Work Requirement while Disabled or during a period of Temporary Recovery, you will not qualify for any increase in insurance.

#### **1.6 INCONTESTABILITY**

When Evidence Of Insurability is required, the Company relies on the information provided. Any statement you make to obtain insurance is a representation and not a warranty. The Company may contest the validity of your insurance or reduce or deny a claim if:

- \* The information you provide contains a misrepresentation;
- \* Your insurance would not have been approved if the Company had known the truth; and
- \* The Company has given you a copy of the written instrument signed by you which contains the misrepresentation.

After your insurance has been in effect for two years, the Company will not use a misrepresentation to contest its validity or reduce or deny your claim for a Disability that begins after the two year period, unless the misrepresentation was fraudulent.

### **SECTION 2. BENEFITS**

#### **2.1 INSURING CLAUSE**

Benefits become payable for your Disability only if:

- \* You become Disabled while insured under the Policy;
- \* You are under the ongoing care of a Physician Or Practitioner;
- \* Your Disability results from an Injury, Sickness, or Pregnancy;
- \* You give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date;

- \* Your Disability is not excluded under **Section 4. Exclusions And Limitations**; and
- \* You meet all other terms of the Policy.

## 2.2 BENEFIT TERMS

**Beginning Date.** This is the date on which benefits begin to accrue after you become Disabled. Benefits are not payable for the time you are Disabled before the Beginning Date. See **Specifications**.

**Maximum Benefit.** Your Maximum Benefit is shown in the **Specifications**.

**Minimum Benefit.** Your Minimum Benefit is shown in the **Specifications**.

**Maximum Benefit Period.** This is the longest period for which benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins on the Beginning Date. No benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Specifications**.

**Predisability Earnings.** Your Predisability Earnings for each uninterrupted period of Disability will be the Predisability Earnings in effect on the date shown in the **Specifications**. Any change in your earnings after that date will not affect your Predisability Earnings.

Predisability Earnings means your weekly rate of earnings from your Employer, including:

- \* Contributions you make through a salary reduction agreement with your Employer to:
  - (1) An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), or 457 deferred compensation arrangement;
  - (2) An executive, nonqualified deferred compensation arrangement; or
  - (3) An IRC Section 125 plan;
- \* Commissions averaged over the Earnings Period shown in the **Specifications** or over the period of your employment if less than the Earnings Period; and
- \* Shift differential pay.

Predisability Earnings does not include:

- \* Bonuses;
- \* Overtime pay;
- \* Your Employer's contributions on your behalf to any deferred compensation arrangement, pension plan, or benefit plan; and
- \* Any other extra compensation.

If you are paid on an annual contract basis, your weekly rate of earnings is one-fifty-second (1/52nd) of your annual contract salary.

If you are paid hourly, your weekly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week, but not more than 40 hours. If you do not have regular work hours, your weekly rate of earnings is based on the average number of hours

you worked per week during the preceding 52 calendar weeks (or during your period of employment if less than 52 weeks), but not more than 40 hours.

**Injury.** This is an injury to your body.

**Mental Disorder.** This is any disease, condition or disorder, whether organic or inorganic, customarily within the scope of treatment of psychiatrists, psychologists, psychotherapists or counselors. This includes, but is not limited to:

- \* psychosis, psychoneurosis, anxiety and depression; and
- \* behavioral, adjustment, emotional, personality and stress-related disorders.

**Physician Or Practitioner.** This is a licensed medical professional, other than yourself, acting within the scope of the license. If Disability is primarily due to any Mental Disorder, Physician or Practitioner means a psychiatrist or licensed doctoral level psychologist, other than yourself.

**Pregnancy.** This is your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

**Sickness.** This is your sickness, illness, or disease.

## 2.3 DEFINITION OF DISABILITY

You are Disabled if you meet either of the following definitions:

- \* Definition of Disability; or
- \* Definition of Partial Disability.

**Definition Of Disability.** You are Disabled if, as a result of Sickness, Injury, or Pregnancy, you are unable to perform with reasonable continuity the Material Duties of your Own Occupation.

**Definition Of Partial Disability.** You are Partially Disabled if you are working for your Employer but, as a result of Sickness, Injury, or Pregnancy, are unable to earn more than the Partial Disability Income Percentage shown in the **Specifications**.

**Own Occupation.** This is any employment, business, trade, profession calling or vocation that involves Material Duties of the same general character as your regular and ordinary employment with your Employer. Your Own Occupation is not limited to your specific job with your Employer or to your specific area of specialization, interest or expertise within the general occupation.

**Material Duties.** These are the essential tasks, functions and operation, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation.

## 2.4 WORKING WHILE DISABLED

You may accrue days toward the Beginning Date while working if you are Disabled.

During the Maximum Benefit Period, benefits are payable while you are working if you are Disabled. However, one-half of your Work Earnings will be used to reduce your benefit as shown in **2.5 Benefit Amounts**.

## 2.5 BENEFIT AMOUNTS

The benefit payable during your Disability will be one of the benefits described in this section, subject to the Maximum Benefit and Minimum Benefit shown in the **Specifications**.

**STD Benefit.** This is your Maximum Benefit minus your Other Income. Your Maximum Benefit is shown in the **Specifications**.

**Return To Work 50% Offset Benefit.** This is your STD Benefit minus one-half of your Work Earnings.

**Work Earnings.** This is your gross weekly earnings from work you perform for your Employer while Disabled. Your earnings will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than weekly, the Company will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, the Company will use a reasonable one.

**Hospital.** This is a legally operated facility identified as a hospital and providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. "Hospital" does not include rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational or rehabilitative care.

When a Disability lasts for a part of a week, 1/7th of the full benefit will be payable for each day you are Disabled.

## 2.6 ASSIGNMENT

The rights and benefits under the Policy are not assignable.

## 2.7 CONTINUATION OF BENEFITS

Your right to receive benefits for a period of Disability which begins while you are insured will not be affected by:

- \* Termination of the Policy after you become Disabled;
- \* Termination of your insurance while the Policy remains in force; or
- \* Any amendment to the Policy approved after the date you become Disabled.

## 2.8 WHEN BENEFITS END

Your benefits end automatically on the earliest of:

- \* The date long term disability benefits become payable to you under a group LTD insurance policy issued by the Company;
- \* The date you are no longer Disabled;
- \* The date your Maximum Benefit Period ends; and
- \* The date you die.



## SECTION 3. BENEFIT PROVISIONS

### 3.1 OTHER INCOME

**Other Income.** The amounts below are Other Income:

- \* The amount of your sick pay or other salary continuation (but not vacation pay) paid to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;
- \* Any amount you receive or are eligible to receive as a result of your disability under any state unemployment compensation disability benefit law or state disability income benefit law; and
- \* Any amount you receive or are eligible to receive due to compromise, settlement, or other method as a result of a claim for any Other Income, whether disputed or undisputed.

### 3.2 RULES FOR OTHER INCOME

**Weekly Equivalents.** Each week the Company will determine your benefit using the Other Income attributable to the same weekly period, even if you actually receive the Other Income in another week.

If you are paid Other Income in a lump sum or by a method other than weekly, the Company will determine your benefit using a prorated amount. The Company will use the period of time to which the Other Income applies. If no period of time is stated, the Company will use a reasonable one.

**Your Duty To Pursue Other Income.** You must pursue Other Income for which you may be eligible. The Company may ask for written documentation of your pursuit of Other Income. You must provide satisfactory documentation within 60 days after the Company mails you a request. Otherwise, the Company may reduce your benefits by the amount the Company estimates you would be eligible to receive upon proper pursuit of the Other Income. You must notify the Company of the amount of the Other Income when it is approved.

**Overpayment Of Claim.** You must immediately repay the Company any overpayment of your claim. The Company will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by the Company. You will not receive any benefits until the Company has been repaid in full. In the meantime, any benefits paid, including the Minimum Benefit, will be applied to reduce the amount of the overpayment. The Company may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after the Company first mails you notice of the amount of the overpayment.

### 3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES

You may temporarily recover from your Disability, and then become Disabled again from the same cause or causes, without having to start accruing days toward a new Beginning Date.

**Temporary Recovery.** This means you cease to be Disabled for no more than the following allowable period:

**Allowable Period.** The allowable period of recovery during the Maximum Benefit Period is 14 days.

### **Effect Of Your Temporary Recovery:**

- \* The Predisability Earnings used to determine your benefit will not change;
- \* The period of Temporary Recovery will not count toward your Maximum Benefit Period;
- \* No benefits will be payable for the period of Temporary Recovery; and
- \* Except as stated above, the provisions of the Policy will be applied as if there had been no interruption of your Disability.

**Separate Disabilities.** Each time you cease to be Disabled for more than the allowable period, a new Maximum Benefit Period applies.

### **3.4 EXTENDED DISABILITY**

If a period of Disability is extended by a new cause while benefits are payable, benefits will continue while you remain Disabled. However:

- \* Benefits will not continue beyond the end of the original Maximum Benefit Period; and
- \* **Section 4. Exclusions And Limitations** will apply to the new cause of Disability.

### **3.5 MISSTATEMENT OF AGE**

If a person's age has been misstated, the Company will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

- \* The amount of insurance based on the correct age; and
- \* The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

## **SECTION 4. EXCLUSIONS AND LIMITATIONS**

### **4.1 EXCLUSIONS**

You are not covered for a Disability:

- \* Arising out of or in the course of any employment for wage or profit;
- \* Caused or contributed to by intentionally self-inflicted injury, while sane or insane; or
- \* Caused or contributed to by War or any act of War.

**War.** This is declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

### **4.2 LIMITATIONS**

**Care Of A Physician Or Practitioner.** You must be under the ongoing care of a Physician Or Practitioner during your Disability. No benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician Or Practitioner.

**Occupational Benefits.** No benefits will be paid for any period when you are eligible to receive benefits under a workers' compensation law or similar law. If your claim for these benefits is accepted, compromised, or settled (whether disputed or undisputed), you must repay the Company for the full amount of any payments the Company makes to you while your claim for occupational benefits is pending.

**Working.** No benefits will be paid for any period when:

- \* You are working for wage or profit for any employer other than your Employer; or
- \* You are self-employed.

#### **4.3 CONTINUITY OF COVERAGE**

The Continuity of Coverage provision changes other provisions found in the Policy.

**Waiver Of Active Work Requirement.** If you were insured under the Prior Plan on the day before the effective date of your Employer's insurance under the Policy, you can become insured on the effective date of your Employer's insurance without meeting the Active Work Requirement.

The benefit payable for a period of continuous Disability beginning before you meet the Active Work Requirement will be:

- \* The weekly benefit which would have been payable under the terms of the Prior Plan if it had remained in force; reduced by
- \* Any benefits payable under the Prior Plan.

There is no Minimum Benefit if there is a reduction because of benefits payable under the Prior Plan.

### **SECTION 5. TERMINATION**

#### **5.1 WHEN INSURANCE ENDS**

Your insurance ends automatically on the earliest of:

- \* The date the last period ends for which you made a premium contribution, if your insurance is Contributory;
- \* The date the Policy terminates;
- \* The date your employment terminates; and
- \* The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued during the following periods, unless it ends on one of the dates shown above:

- (1) While you are receiving from your Employer at least the amount of Predisability Earnings in effect immediately before you ceased to be a Member;
- (2) While you are Disabled before the Beginning Date and while benefits are payable;

- (3) During a leave of absence if continuation of your insurance under the Policy is required by the state mandated family or medical leave act or law; or
- (4) During any other leave of absence approved by your Employer in advance and in writing and scheduled to last the period shown in the **Specifications**.

## **5.2 REINSTATEMENT OF INSURANCE**

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- \* If your insurance ends because you cease to be a Member, and if you become a Member again within 90 days, the Eligibility Waiting Period For Insurance will be waived;
- \* If your insurance is Contributory and ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again; and
- \* If your insurance ends because you are on a federal or state mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

## **SECTION 6. CLAIMS**

### **6.1 FILING A CLAIM**

Claims should be filed on the Company's forms. If you do not receive the Company's forms within 15 days after you ask for them, you may submit your claim in a letter to the Company. The letter should include the date your disability began, and the cause and nature of your disability.

### **6.2 PROOF OF LOSS**

You must give the Company satisfactory Proof Of Loss within 90 days after the Beginning Date. If you cannot do so, you must give it to the Company as soon as reasonably possible, but not later than one year after that 90 day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

**Proof Of Loss.** This means written proof that you are Disabled and entitled to benefits. Proof Of Loss must be provided at your expense.

### **6.3 DOCUMENTATION**

At your expense, you must submit completed claims statements, your signed authorization for the Company to obtain information, and any other items the Company may reasonably require in support of your claim. If you do not provide the documentation within 45 days after the Company mails you a request, your claim may be denied.

### **6.4 TIME OF PAYMENT**

The Company will pay benefits within 30 days after you provide satisfactory Proof Of Loss. Benefits will be paid at the end of each week you qualify for them.

## **6.5 PAYMENT OF CLAIM**

Benefits will be paid to you. Benefits remaining unpaid at your death will be paid to your estate.

## **6.6 INVESTIGATION OF CLAIM**

The Company may investigate your claim at any time. At its own expense, the Company may have you and your financial records examined as often as is reasonably necessary. This will be done by specialists of the Company's choice. The Company may deny or suspend benefits if you fail to attend an examination or cooperate with the examiner.

## **6.7 NOTICE OF DECISION ON CLAIM**

The Company will evaluate your claim promptly after you file it. Within 45 days after the Company receives your claim the Company will send you: (a) a written decision on your claim; or (b) a notice that the Company is extending the period to decide your claim for 30 days. Before the end of this extension period the Company will send you: (a) a written decision on your claim; or (b) a notice that the Company is extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If the Company extends the period to decide your claim, the Company will notify you of the following: (a) the reasons for the extension; (b) when the Company expects to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information the Company needs to resolve those issues.

If the Company requests additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, the Company may decide your claim based on the information the Company has received.

If the Company denies any part of your claim, you will receive a written notice of denial containing:

- \* The reasons for the decision.
- \* Reference to the parts of the Policy on which the decision is based.
- \* Reference to any internal rule or guideline relied upon in making the decision.
- \* A description of any additional information needed to support your claim.
- \* Information concerning your right to a review of the decision.
- \* Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

## **6.8 REVIEW PROCEDURE**

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after you receive notice of the denial.

You may send the Company written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review.

There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to the Company about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgement, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgement in connection with the denied claim and will not be subordinate to that person. The Company's review will include any written comments or other items you submit to support your claim.

The Company will review your claim promptly after the Company receives your request. Within 45 days after the Company receives your request for review the Company will send you: (a) a written decision on review; or (b) a notice that the Company is extending the review period for 45 days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

If the Company extends the review period, the Company will notify you of the following: (a) the reasons for the extension; (b) when the Company expects to decide your claim on review; and (c) any additional information the Company needs to decide your claim.

If the Company requests additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, the Company may conclude the review of your claim based on the information the Company has received.

If the Company denies any part of your claim on review, you will receive a written notice of denial containing:

- \* The reasons for the decision.
- \* Reference to the parts of the Policy on which the decision is based.
- \* Reference to any internal rule or guideline relied upon in making the decision.
- \* Information concerning your right to receive free of charge copies of non-privileged documents and records relevant to your claim.
- \* Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

The Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

## **6.9 TIME LIMITS ON LEGAL ACTIONS**

No action at law or in equity may be brought until 60 days after you have given the Company Proof Of Loss. No such action may be brought more than three years after the earlier of:

- \* The date the Company receives Proof Of Loss; and
- \* The end of the period within which Proof Of Loss is required to be given.

## SECTION 7. ALLOCATION OF AUTHORITY

Except for those functions which the Policy specifically reserves to the Policyowner, the Company has full and exclusive authority to control and manage the Policy, to administer claims, and to interpret the Policy and resolve all questions arising in the administration, interpretation, and application of the Policy.

The Company's authority includes, but is not limited to:

- \* The right to resolve all matters when a review has been requested;
- \* The right to establish and enforce rules and procedures for the administration of the Policy and any claim under it;
- \* The right to determine:
  - (1) Your eligibility for insurance;
  - (2) Your entitlement to benefits;
  - (3) The amount of benefits payable to you;
  - (4) The sufficiency and the amount of information the Company may reasonably require to determine 1, 2, or 3 above.

## SECTION 8. PREMIUMS

### 8.1 AMOUNTS

The premium due on each Premium Due Date is the sum of the premiums for all Members then insured. The Policyowner determines the amount, if any, of each insured Member's contribution toward the cost of insurance.

### 8.2 CHANGES

The Company may change Premium Rates when:

- \* A change in law or governmental regulation affects the amount payable under the Policy. Any such change in Premium Rates will reflect only the change in the Company's obligations;
- \* The number of insured Members changes by 25% or more; or
- \* The Company and the Policyowner mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in the **Specifications**. Thereafter, the Company may change Premium Rates upon advance written notice to the Policyowner. The minimum advance notice is shown in the **Specifications** as the Advance Notice Period. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

### **8.3 PAYMENT OF PREMIUM**

All premiums are due on the Premium Due Dates shown in the **Specifications**.

Each premium is payable on or before its Premium Due Date directly to the Company's Group Administration Office. The payment of each premium as it becomes due will maintain the Policy in force until the next Premium Due Date.

### **8.4 GRACE PERIOD**

The Grace Period shown in the **Specifications** will be allowed for payment of a premium that is not paid on its due date. The Policy will be in force during this period. If the premium is not paid during the Grace Period, the Policy will terminate automatically at the end of the Grace Period. The Policyowner is liable for the payment of premium for coverage provided during the Grace Period. The Company may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

### **8.5 PREMIUM ADJUSTMENTS**

Premium adjustments involving a return of unearned premiums to the Policyowner will be limited to the 12 months just before the date the Company receives a request for premium adjustment.

## **SECTION 9. THE CONTRACT**

### **9.1 ENTIRE CONTRACT, CHANGES**

The Policy, the application of the Policyowner and the individual application of persons insured constitute the entire contract between the parties. A copy of the Policyowner's application is attached to the Policy when issued.

The Policy may be changed in whole or in part. No change in the Policy will be valid unless it is approved in writing by one of the Company's executive officers and given to the Policyowner for attachment to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

### **9.2 INCONTESTABILITY OF POLICY**

Any statement made by the Policyowner to obtain the Policy is a representation and not a warranty.

No misrepresentation by the Policyowner will be used to deny a claim or to deny the validity of the Policy unless:

- \* The Policy would not have been issued if the Company had known the truth; and
- \* The Company has given the Policyowner a copy of a written instrument signed by the Policyowner which contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

### **9.3 DIVIDENDS**

While the Policy is in force, it will be credited with its share, if any, of the divisible surplus in the form of dividends which the Company may declare.



If required by state law, the Policyowner will use, for the sole benefit of the insured Members, the amount of such dividends or rate reductions which exceeds the Policyowner's expenditure for insurance under the Policy.

#### **9.4 CERTIFICATES**

The Company will issue certificates to the Policyowner showing the coverage under the Policy. The Policyowner will distribute a certificate to each insured Member.

#### **9.5 RECORDS AND REPORTS**

The Policyowner or Employer will furnish on the Company's forms all information reasonably necessary to administer the Policy. The Company has the right at all reasonable times to inspect the payroll and other records of the Policyowner or Employer which relate to insurance under the Policy.

Clerical error by the Policyowner or Employer will not:

- \* Cause a person to become insured;
- \* Invalidate insurance otherwise validly in force; or
- \* Continue insurance otherwise validly terminated.

#### **9.6 EFFECT ON WORKERS' COMPENSATION, STATE DISABILITY INSURANCE**

The coverage provided under the Policy is not a substitute for coverage under a workers' compensation or state disability income benefit law. The Policy does not relieve the Employer of any obligation to provide such coverage.

#### **9.7 TERMINATION OF CONTRACT**

The Policyowner may terminate the Policy by giving the Company advance written notice. The effective date of termination will be the later of:

- \* The date stated in the notice; and
- \* The date the Company receives the notice.

The Company may terminate the Policy upon advance written notice as follows:

- \* On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number or less than the Minimum Participation Percentage shown in the **Specifications**.
- \* On any Premium Due Date if the Company determines that the Policyowner has failed to promptly furnish any necessary information requested by the Company, or has failed to perform any other obligations relating to the Policy.

The minimum advance notice is shown in the **Specifications** as the Advance Notice Period.

SERFF Tracking Number: NWST-128300321 State: Arkansas

Filing Company: The Northwestern Mutual Life Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term

Product Name: MN 992-STD/0911

Project Name/Number: MN 992-STD/0911/MN 992-STD/0911

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/07/2012	Form	Amendment Group Short Term Disability Policy	06/29/2012	MN 992 STD 0911.pdf (Superceded)
05/07/2012	Form	Amendment Group Short Term Disability Certificate	06/29/2012	MN 992 STDC 0911.pdf (Superceded)
05/24/2012	Supporting Document	previously approved MN 992-LTD and MN 992-LTDC July 30, 1993	05/24/2012	MN 992-STD-STDC.pdf

## AMENDMENT TO GROUP SHORT TERM DISABILITY INSURANCE POLICY FORM

Attached to and made a part of Group Policy Form MN 992-STD

Group Policy Form MN 992-STD is amended to provide an update to policy language and to provide the following provisions for any Policyowner who negotiates the inclusion of such provisions into its Short Term Disability policy issued by us. The use of brackets ( [ ] ) indicate the language is optional or variable; optional language is either included or removed in entirety, while variable language shows possible language choices or the most common number range used within the brackets.

1. In order to provide loss of license language, **SECTION 2.3 DEFINITION OF DISABILITY**, is amended to add the following language:

**[Optional:**

Note: you are not Disabled from your Own Occupation merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license. The loss of a professional license, occupational license, or certification does not, in itself, constitute Disability.]

2. **SECTION 2.3 DEFINITION OF DISABILITY** is amended to add the following language:

**[Optional:**

**Own Occupation.** This is the job you are regularly performing for your Employer when Disability begins.]

**[Optional:**

**Material Duties.** These are the usual duties you perform in your regular job with your Employer.]

3. **SECTION 2.5 BENEFIT AMOUNTS**, is amended to add the following language:

**[Optional:**

**Return To Work Benefit.** The Return To Work Benefit will be paid in place of your STD Benefit, if you are working while Disabled. Your Return To Work Benefit equals your STD Benefit minus the amount of your **[Optional; Work Earnings,]** **[Optional; sick pay,]** **[Optional; annual or personal leave pay,]** **[Optional; severance pay,]** **[Optional; Paid Time Off,]** **[Optional; or other salary continuation,]** **[Optional; including donated amounts]** **[Optional; (but not vacation pay)]** **[Optional; or Paid Time Off)]** which, when added to your STD Benefit, exceeds **[Variable; 100%]** of your Predisability Earnings.

4. The following sections are amended to add Paid Time Off as follows:

**SECTION 4. EXCLUSIONS AND LIMITATIONS** of the **SPECIFICATIONS** section:

**4.2 LIMITATIONS**

**[Optional Limitation:**

\* **[Variable;** Paid Sick Leave;

**- Or -**

Paid Time Off]

**SECTION 2. BENEFITS**

**2.2 BENEFIT TERMS**

**[Optional;**

**Paid Time Off.** This is **[Variable;** e.g. vacation pay/sick pay/annual or personal leave pay] provided by your Employer.]

**SECTION 3. BENEFIT PROVISIONS**

**3.1 OTHER INCOME**

**Other Income.** The amounts below are Other Income:

**[Optional:**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer;

**- Or -**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;]

**SECTION 4. EXCLUSIONS AND LIMITATIONS**

**4.2 LIMITATIONS**

**[Optional:**

**Paid Sick Leave.** No benefits will be paid for any period when you are receiving **[Optional;** paid sick leave] **[Optional;** Paid Time Off] from your Employer.]

5. **SECTION 3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES**, is amended to add the following optional language:

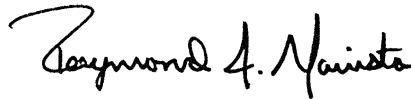
**[Optional:**

**Cancer Treatment Benefit.** When you are undergoing chemotherapy or radiation treatment at the direction of a Physician Or Practitioner, your Beginning Date will be the **[Variable; first day]** of each period of Disability, **[Optional;** and the Allowable Period for Temporary Recovery And Separate Disabilities for the Cancer Treatment Benefit will be **[Variable; 14-180 days]]**.

**[Optional;** Note: If you have previously received STD Benefits for Disability resulting from the same cause or causes, the Beginning Date will not be retroactively adjusted to the first day.]]

The Northwestern Mutual Life Insurance Company

By

A handwritten signature in black ink, reading "Raymond A. Mainster". The signature is written in a cursive style with a large, stylized 'R' and 'M'.

Secretary

## AMENDMENT TO GROUP SHORT TERM DISABILITY INSURANCE CERTIFICATE FORM

Attached to and made a part of Group Certificate Form MN 992-STDC

Group Certificate Form MN 992-STDC is amended to provide an update to certificate language and to provide the following provisions for any Policyowner who negotiates the inclusion of such provisions into its Short Term Disability policy issued by us. The use of brackets ( [ ] ) indicate the language is optional or variable; optional language is either included or removed in entirety, while variable language shows possible language choices or the most common number range used within the brackets.

1. In order to provide loss of license language, **SECTION 2.3 DEFINITION OF DISABILITY**, is amended to add the following language:

**[Optional:**

Note: you are not Disabled from your Own Occupation merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license. The loss of a professional license, occupational license, or certification does not, in itself, constitute Disability.]

2. **SECTION 2.3 DEFINITION OF DISABILITY** is amended to add the following language:

**[Optional:**

**Own Occupation.** This is the job you are regularly performing for your Employer when Disability begins.]

**[Optional:**

**Material Duties.** These are the usual duties you perform in your regular job with your Employer.]

3. **SECTION 2.5 BENEFIT AMOUNTS**, is amended to add the following language:

**[Optional:**

**Return To Work Benefit.** The Return To Work Benefit will be paid in place of your STD Benefit, if you are working while Disabled. Your Return To Work Benefit equals your STD Benefit minus the amount of your **[Optional; Work Earnings,]** **[Optional; sick pay,]** **[Optional; annual or personal leave pay,]** **[Optional; severance pay,]** **[Optional; Paid Time Off,]** **[Optional; or other salary continuation,]** **[Optional; including donated amounts]** **[Optional; (but not vacation pay]** **[Optional; or Paid Time Off)]** which, when added to your STD Benefit, exceeds **[Variable; 100%]** of your Predisability Earnings.

4. The following sections are amended to add Paid Time Off as follows:

**SECTION 4. EXCLUSIONS AND LIMITATIONS** of the **SPECIFICATIONS** section:

**4.2 LIMITATIONS**

**[Optional Limitation:**

\* **[Variable;** Paid Sick Leave;

**- Or -**

Paid Time Off]

**SECTION 2. BENEFITS**

**2.2 BENEFIT TERMS**

**[Optional;**

**Paid Time Off.** This is **[Variable;** e.g. vacation pay/sick pay/annual or personal leave pay] provided by your Employer.]

**SECTION 3. BENEFIT PROVISIONS**

**3.1 OTHER INCOME**

**Other Income.** The amounts below are Other Income:

**[Optional:**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer;

**- Or -**

\* The amount of your **[Optional;** sick pay] **[Optional;** Paid Time Off] or other salary continuation **[Optional;** (but not vacation pay)] **[variable;** paid, payable] to you by your Employer which, when added to your Maximum Benefit, exceeds 100% of your Predisability Earnings;]

**SECTION 4. EXCLUSIONS AND LIMITATIONS**

**4.2 LIMITATIONS**

**[Optional:**

**Paid Sick Leave.** No benefits will be paid for any period when you are receiving **[Optional;** paid sick leave] **[Optional;** Paid Time Off] from your Employer.]

5. **SECTION 3.3 TEMPORARY RECOVERY AND SEPARATE DISABILITIES**, is amended to add the following optional language:

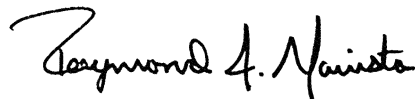
**[Optional:**

**Cancer Treatment Benefit.** When you are undergoing chemotherapy or radiation treatment at the direction of a Physician Or Practitioner, your Beginning Date will be the **[Variable; first day]** of each period of Disability, **[Optional;** and the Allowable Period for Temporary Recovery And Separate Disabilities for the Cancer Treatment Benefit will be **[Variable; 14-180 days]]**.

**[Optional;** Note: If you have previously received STD Benefits for Disability resulting from the same cause or causes, the Beginning Date will not be retroactively adjusted to the first day.]]

The Northwestern Mutual Life Insurance Company

By

A handwritten signature in black ink, appearing to read "Raymond A. Mainster". The signature is written in a cursive, flowing style.

Secretary